Report of the Health Service Commissioner

Selected Investigations completed April-September 1981

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HEALTH SERVICE COMMISSIONER

First Report for Session 1981–82

Selected Investigations completed April–September 1981

Presented to Parliament pursuant to Section 119(4) of the National Health Service Act 1977 and Section 96(5) of the National Health Service (Scotland) Act 1978, as amended by The Health Services Act 1980.

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Section 119(4) of the National Health Service Act 1977 and Section 96(5) of the National Health Service (Scotland) Act 1978, as amended by the Health Services Act 1980, empower me as Health Service Commissioner for England, for Scotland and for Wales to make such reports to the Secretaries of State with respect to my functions as I think fit.

The Appendix to this Report contains a selection of the individual reports issued during the months April–September 1981 and one soon afterwards. Those for England have the prefix 'W', those for Scotland the prefix 'SW' and those for Wales the prefix 'WW'.

C M CLOTHIER
Health Service Commissioner

October 1981

APPENDIX

This selection of 29 reports is taken from a total of 50 cases on which full investigations were completed during the period April – September 1981. I issued one of these reports concurrently with one issued by the Commission for Local Administration (indicated with *).

CONTENTS

Case No. W.218/78–79 – Communications with parents of injured child and handling of complaint

Background and complaint

1. On the evening of 7 July 1977, following an accident, the complainant's son, who was then just under three years old, was seen in the Accident and Emergency Department (the A and E department) of a General Hospital (the hospital) suffering from a suspected fracture of the clavicle and abrasions to his back. He was discharged soon after midnight.

2. The complainant approached me in 1979 and complained that:

(*a*) the senior house officer (the SHO) in the A and E department failed to answer questions raised by him and to give the explanations he requested;

(*b*) the medical and nursing staff gave conflicting information about the use of general anaesthetic;

(*c*) a spray which a casualty nurse gave him to be applied to his son's wound had not been prescribed by a doctor;

(*d*) the consultant was unhelpful both during his son's treatment and during the enquiries into his complaint made by the Area Health Authority (the AHA), and refused to see him to discuss his son's treatment; and

(*e*) in handling the complaint, which was made in a series of letters containing paragraphs numbered 1 – 75, the AHA:

(i) repeatedly failed to reply satisfactorily to the points he raised in paragraphs 4, 28 and 33 of his correspondence, the details of which I shall refer to later;

(ii) did not answer his questions about the hospital's policy in relation to parents' rights to be given information about the medical treatment of their children but, instead, shifted part of the blame for poor communication on to him and his wife; and

(iii) were unhelpful, inaccurate and unnecessarily curt.

Investigation

3. During my investigation I obtained comments from the AHA and I examined these and other relevant papers. My officers obtained evidence from the medical, nursing and administrative staff involved and they also met the complainant.

(a) and (b) *The complaint about the SHO and the conflicting information about the anaesthetic*

4. The complainant told my officers that, after his son had arrived at the hospital, accompanied by his parents, he was x-rayed and then taken to another room where a nurse indicated that she would like the complainant and his wife to wait outside while she scrubbed the abrasion. The complainant said that he and his wife did not want to appear unco-operative but felt that it was in their son's best interests that they should stay with him. The treatment was therefore started with them looking on but, after a short while, because their son seemed

to be in great distress, the complainant told the nurse that the treatment seemed inhuman and asked if an alternative form of treatment was available or if an anaesthetic might be suitable. The nurse, he said, left the room in a state of apparent indignation and the boy and his parents were shown into another room. Some five minutes later, another member of the nursing staff arrived and suggested to the complainant and his wife that the use of an anaesthetic on so young a child was a somewhat drastic measure. The complainant reaffirmed that it seemed inhuman to carry on scrubbing the wound as it was causing his son so much pain and distress.

5. The complainant said that the SHO and a nursing officer (the NO) were called to attend. The complainant described the ensuing conversation to my officers as a farce. He said that he enquired about the use of an anaesthetic and the SHO made reference to a 'figure-of-eight' bandage which, to the complainant, seemed to bear no relevance to his enquiry. He told my officers that the SHO seemed neither to understand the situation nor to be able to speak English competently; the NO had tried to help the SHO and had explained to him that it was his decision whether or not an anaesthetic should be used.

6. The complainant went on to tell my officers that after this conversation the SHO had withdrawn and returned with another, apparently senior, doctor whom I have identified as the senior casualty officer (the SCO). The SCO expressed the view that the complainant's son ought to be treated under general anaesthetic and the complainant said that he became alarmed at the conflicting views: the SHO had decided upon treatment without any anaesthetic; a member of the nursing staff had expressed the view that to administer a general anaesthetic to such a young child was a drastic measure; and the SCO had then said that he thought the complainant's son *ought* to be treated under general anaesthetic. The complainant said that he tried to point out this discrepancy but met with little co-operation or explanation until a doctor (he was, in fact, an anaesthetist) spoke to them and, on his advice, they agreed to further treatment under general anaesthetic.

7. I have seen from a statement made by the NO some seven weeks after the event that when the SHO had seen the x-ray he diagnosed a fractured left clavicle and requested that a figure-of-eight bandage be applied. The NO recorded also that a state enrolled nurse (the first SEN) attempted to clean the friction burn, which covered an area approximately 8″ x 6″, using Savlon and gauze. I have seen from the first SEN's statement, made at about the same time, that a soft brush was also used to help clean the friction burn. Both the NO and the first SEN recorded in their statements that a mild analgesic was given to the complainant's son to help relieve his discomfort. The first SEN's statement also confirmed that the complainant and his wife insisted on staying with their son and that it was the complainant who first mentioned the possibility of an anaesthetic being administered.

8. The NO's statement records: 'At approximately 8.30 pm I saw [the complainant and his wife] along with [the SHO]. Both [parents] asked [the SHO] if it was possible for their son to be given a local anaesthetic before the abrasions were cleaned. [The SHO] did not understand and went on about a local anaesthetic not being required for the application of a figure 8 bandage. [The parents] repeated the question but got the same answer. I then tried to ask the

same question but to no avail. I then explained to [them] that to give a local anaesthetic for such an area the number of injections would cause [their son] considerable pain, but this was a decision which could only be made by the medical staff. As [the SHO] could not reach any decision I suggested to him that he contact [the SCO] who had just come into the department.' The NO told my officer that he had no doubt whatsoever that the SHO had had difficulty in understanding what the complainant and his wife were 'getting at'.

9. The SHO told my officer that, when he saw the complainant's son, he had been at the hospital only about two weeks and that this was his first job in England. He said that, at the time, neither his understanding of the spoken English word, particularly when spoken with a Yorkshire accent, nor his own spoken English, was as good as it might have been. But his medical training had been undertaken in English. He said that he knew of the risks of anaesthetising young children and, although he could not remember the particular case, this would have been a factor which he took into consideration when deciding what treatment to offer the complainant's son. The SCO told my officer that he could not remember this case being brought to his attention but thought he might well have advised the SHO to treat the child under a general anaesthetic. However, he had no recollection of speaking to the parents.

10. My officer also interviewed the consultant in charge of the A and E department. He said that the SHO, as a registered doctor, had every right to decide upon, and adopt, a course of treatment for a patient. He said that, because of the extent of the abrasions, he himself would probably not have treated the complainant's son without the administration of an anaesthetic.

Findings

11. I uphold the first of these complaints to the extent that I am satisfied by the evidence that the SHO did not answer the parents' questions properly because he could not understand them. That amounted to a failure in the service. But I do not uphold the second complaint, because professional staff are entitled to differ on matters of clinical judgment, especially as to whether a young child should be given a general anaesthetic, and it is not for me to say that there is only one valid opinion on the point.

(c) *The complaint about the issue of the spray*

12. The complainant told my officers that he and his wife returned with their son to the hospital on 9 July when, after some apparent hesitation by the nursing staff about what exactly was required, the figure-of-eight bandage was replaced. He was not examined by a member of the medical staff. Before the complainant and his wife left the hospital they were supplied with a spray canister and they were told to use the spray, three times daily, on the part of the abrasion not covered by the figure-of-eight bandage. On Monday 11 July, after his son had been seen by the consultant, the complainant received a telephone call from his wife to say that the consultant wanted to admit their son to the Children's Ward (the ward) and that he had told her that the spray should not have been used.

13. All the nursing staff on duty in the A and E department on the morning of 9 July were interviewed by my officer and none of them could recall either a spray canister being given to the complainant and his wife or could imagine any

circumstances in which a spray would have been issued without a doctor's consent. During the AHA's investigation of the complaint a nursing auxiliary made a statement to the effect that the SCO had left instructions with her that the complainant's son's dressing was to be removed and the abrasion left exposed. She told my officer that the SCO had left this instruction with her because he had been called away to the operating theatre. However, when the dressing was removed, the abrasions were found to be bleeding slightly and it was necessary to replace the dressing.

14. My officer asked to see the casualty card (which would normally have recorded the treatment given) for Saturday 9 July but no entry for this date could be found. It was evident from the casualty card entries which were available that any entry for Saturday 9 July which might have been made would have been the first on a fresh continuation sheet; but the only continuation sheet available was one bearing an entry for 11 July. The district nursing officer (the DNO) told my officer that when a patient reports to the reception desk in the A and E department the casualty card is sent round to the treatment area and, when the nursing and medical staff are ready, the patient is called for examination and treatment and the card is completed. None of the nursing staff on duty could recall any problem about a casualty card for the complainant's son not being available at the time and one, a male staff nurse, remarked that it would have been memorable had the card *not* been there for completion. No entry for treatment given to the complainant's son on Saturday 9 July could be found in any other of the medical and nursing records.

15. The DNO told my officer that it was not possible to check whether a prescription had been made out for the spray canister as the prescription forms were destroyed after two years.

16. When the complainant first raised this complaint with the AHA, they replied: 'The spray canister, although obviously not harmful to your son, should not have been given to you as instructions had not been given to that effect.'

Findings

17. Although I have been unable to establish exactly what happened, the AHA have admitted that there were no instructions to issue the spray canister. This incident should not have occurred. But I do not uphold the complaint because I see no evidence that the complainant suffered significant hardship in this connection.

(d) *The complaint about the consultant's attitude*

18. The complainant told my officers that his wife had taken their son to the hospital on Monday 11 July where she had seen the consultant. In his initial letter of complaint to the AHA, the complainant explained that his wife had been told by the consultant that she should not have used the spray and when she had asked whether alternatively it would be appropriate to apply some sort of cream to help the healing process the consultant told her not to teach him his job. The complainant said that following the telephone call from his wife (paragraph 12), he had gone to the ward where he expressed to the consultant some concern about his son's treatment. He told my officers that the consultant had been abrupt, unco-operative and apparently resentful. In his letter to the

AHA he said that the consultant 'simply side-stepped the specific points I raised by suggesting that he be allowed to concentrate on the child'. The complainant said that the consultant had suggested that he should refer his complaints 'to the authorities'.

19. In a statement the consultant made in response to the AHA's investigation of the initial complaint, he confirmed that the complainant's wife had questioned him when she brought their son to the hospital on 11 July and went on to say 'in spite of repeated interruptions by the mother, who appeared to be quite oblivious of the condition of the poor child, I completed my examination and advised immediate admission . . .'. As regards his meeting on the ward with the complainant the consultant stated: 'I was confronted by the father in the middle of the ward and he stated that he had complaints to make. I told him that at that particular moment I must concentrate on the care and treatment of the patients in the ward and I also was not prepared to discuss his complaints in the open ward in front of ill children and the rest of the staff'. The consultant told my officer that he did not feel that there had been 'unpleasantness', but he thought there was a time when the administration should take over and he should be allowed to get on with treating patients without interruption. He subsequently pointed out that he had seen the complainant and his wife when he had reviewed their son's condition on 8 August and that they had not taken the opportunity to talk about their grievances.

20. The AHA's reply to the complainant's initial letter of complaint said that '[the consultant] has confirmed your account of the events which took place on 11 July. It is clear, however, that he was irritated by what he regarded as repeated interruptions from your wife while he endeavoured to examine your son and by your subsequently seeking to discuss with him during the course of a ward round, matters for which he was largely not directly responsible'. In a subsequent letter dated 4 January 1978, the AHA informed the complainant that the consultant had requested them to reply as follows: '[the consultant] maintains that he had carried out treatment to your Son's injury promptly and efficiently leading to a complete cure in the least possible time. He refutes all your allegations and wishes to say that if you have any further complaints concerning his treatment to your Son, then would you please communicate directly with him'.

21. The complainant replied to the effect that he had acted reasonably when he approached the consultant on the ward as also had his wife when she sought information from the consultant about their son's treatment. The consultant's position was, he said, incomprehensible because he had first suggested that the complaints be addressed to the authority, then direct to him; he had confirmed the complainant's account of what happened on 11 July and then 'refuted' the complainant's allegations. The complainant sought clarification of what allegations the consultant referred to and on what basis they were refuted, but this was not forthcoming.

22. In January 1979 a meeting between the Chairman of the AHA and the District Administrator (the DA) was arranged and at this meeting a further one involving the consultant was proposed. On 22 March 1979 the DA wrote to the complainant to say that, while a further meeting could be arranged it would not involve the consultant who, by this time, had consulted his medical defence

organisation. The DA said that neither the consultant nor the defence organisation was willing to provide any additional information about the complaint and the consultant was not prepared to meet the complainant.

23. Amongst the correspondence between the DA and the consultant, there is a letter dated 14 July 1978 in which the consultant referred to the complainant's correspondence as a 'considerable source of nuisance' and said that 'a lot of my valuable time has been wasted in going through this lengthy correspondence for nearly a year'. The consultant told my officer that he was only prepared to go 'so far' in allowing administrative matters of this nature to interfere with his job of treating patients.

Findings

24. I think there was perhaps fault on both sides. I accept the consultant's view that he ought not to be expected to deal with complaints when he is treating a patient or is in the middle of a ward round. This seems to me to be quite right and I think it was unreasonable for the complainant and his wife to have demanded immediate attention to their complaints. But I consider that the protracted correspondence which the consultant complained had wasted so much of his time might have been avoided had he suggested at the outset that they made an appointment to see him at a more appropriate time, rather than rejecting their approach unconditionally.

(e) *The complaint about the AHA's handling of the complaint*

(i) *The AHA repeatedly failed to reply satisfactorily to paragraphs 4, 28 and 33 of the complainant's representations*

25. In paragraph 4 the complainant referred to his encounter with the SHO who was accompanied by the NO (paragraphs 4 and 5 above). The complainant referred to the difficulties in communications and to his impression that the NO was obliged to prompt the SHO in an effort to obtain a decision about the use of an anaesthetic. The complainant referred back to the subject matter of paragraph 4 and the lack of response from the AHA in his paragraphs 19, 31, 36, 42, 48, 54 and 69a. The AHA, in a series of letters between 27 September 1977 and 21 September 1978, pointed out the SHO's right to exercise his clinical judgment, but admitted that the administration of a general anaesthetic might have been the better course of treatment from the start and accepted that the SHO could have dealt with the complainant more tactfully and explained what he was doing and why. They apologised for the shortcomings in the service, but they did not specifically answer the complaint that the SHO was *unable* to understand or communicate with the complainant.

26. The complainant's paragraph 28 (contained in his letter of 12 February 1978) asked for clarification as to which of the two consultants mentioned in the AHA's letter of 4 January 1978 was in charge of the A and E department. The next response to this letter, which contained many other points as well, was a letter dated 6 April 1978 from the DA stating that it was felt that all the points raised in the complainant's letter of 12 February 1978 had been answered. The complainant disputed this and repeated his request for clarification in subsequent paragraphs 36, 42 and 49. In his letter of 7 July 1978 the DA answered the point and admitted that his letter of 4 January had been ambiguous.

27. The complainant's paragraph 33 appears in the same letter as his paragraph 28 and requested that the consultant clarify his position as regards the 'allegations' which he had 'refuted' (see paragraph 21 above). Again the immediate response was that this had been answered and the complainant raised the matter again in his paragraphs 36, 42, 50, 56 and 70. The AHA maintained the stance that the consultant had asked for complaints to be put to him direct; but the complainant pointed out to the DA that he was seeking clarification of information contained in letters signed by the DA and he could therefore see no reason why he should seek clarification elsewhere.

Findings

28. No doubt the DA's handling of these voluminous complaints was less than perfect. He could have dealt with the complainant's paragraph 28 sooner than he did and he might well have commented on the communication difficulties referred to in the complainant's paragraph 4. But in the context of a complaint which was presented in a total of 75 paragraphs running through many letters, these faults seem to me quite trivial. I do not uphold this complaint.

(ii) *The failure of the AHA to answer the complainant's questions about the hospital's policy in relation to parents' rights*

29. In the complainant's initial letter of complaint to the AHA, he alluded to his and his wife's attempts to obtain information about their son's treatment and asked whether it was the hospital's policy to respect the parents' right and moral responsibility to seek information and clarification about the medical treatment of their children. He asked also what measures existed to safeguard the position of parents on this point. In a subsequent letter the complainant asked what measures and/or disciplinary action had been taken as a result of the specific complaints he made about his attempts to seek information about his son's treatment.

30. The AHA told the complainant that it was hospital policy to respect the rights of parents but that the first priority was the treatment of the patient; on occasion, the giving of information to parents had to take second place. They advised the complainant of a leaflet which encourages parents to seek information and said that measures to safeguard parents' rights were unnecessary because all staff were aware of their duty to give appropriate information and advice to parents. The AHA later told the complainant that disciplinary action was not considered appropriate but that junior medical staff in the A and E department had been counselled and nursing and medical secretarial staff reminded about the need to ensure that patients and relatives are given the various information leaflets which are available.

31. As regards the specific complaints about seeking information, the AHA replies pointed out that their (the parents') presence, when the nursing staff wanted to clean their son's wound, made the nursing task difficult; that the consultant was irritated by repeated interruptions from both the complainant and his wife and that the DA had concluded that both the consultant and they were at fault.

Findings

32. I believe that the AHA made a reasonable attempt to answer both the

general points made by the complainant about parental rights to seek information and the specific complaints. The replies certainly do shift part of the blame for poor communications on to the complainant and his wife but I have explained in paragraph 24 above my view that their questions were ill-timed. I do not uphold this complaint.

(iii) *The AHA were unhelpful, inaccurate and curt*

33. The complainant first wrote to the AHA on 14 July 1977. The AHA's investigation into these complaints involved much correspondence with the complainant and two meetings with him and culminated with the complainant's request that I investigate.

Findings

34. The amount of time spent by the AHA in trying to deal with these complaints is not to my mind indicative of unhelpfulness or curtness. Moreover, the complainant's letters were often long and their style convoluted. I am not surprised that amongst the verbiage some of the points got lost. The AHA were certainly inaccurate on the occasion described in paragraph 26 above when they wrote saying that all points raised by the complainant's letter of 12 February 1978 had been dealt with when clearly they had not. Again, I do not regard this lapse as serious nor do I find that it caused significant hardship. So I do not uphold any part of this last complaint.

Conclusions

35. I have given my findings in paragraphs 11, 17, 24, 28, 32 and 34. Only in paragraph 11 have I found fault for which I think the AHA should make some expression of regret, and I am glad to say that they have asked me to convey this through my report. The AHA have explained that, before his appointment, the SHO had undertaken a clinical attachment under a compulsory scheme introduced in November 1969 for doctors from overseas. One of the aims of the scheme was to seek to ensure that doctors had an adequate ability to communicate in English in a clinical situation. Since the complaint arose this has changed and the Medical Act 1978 makes an adequate standard of English a statutory requirement for the registration of doctors with overseas qualifications, and the Department of Health and Social Security have issued guidance to Health Authorities about how they may satisfy themselves of the proficiency in English of applicants for posts. The AHA assure me that the difficulties the complainant experienced in 1977 should not be repeated under the current arrangements.

Case No. W.278/78–79 – Harassment of patient on an acute medical ward

Background and complaint

1. The complainant's husband was admitted to hospital at the age of 66 on 19 March 1978 with a condition diagnosed as myocardial infarction. He was discharged on 1 April 1978.

2. The complainant contended that:

(*a*) her husband was harassed in the ward by a female psychogeriatric

patient (Mrs A) for whom suitable accommodation could not be found; and

(*b*) the nursing care afforded to her husband was in some respects inadequate.

The complainant first approached the Secretary of State for Social Services about the harassment of her husband, but she was dissatisfied with the reply and the apology conveyed to her by the Department, on behalf of the Area Health Authority (the first AHA).

Investigation

3. In the course of the investigation I have corresponded with the first AHA and with another Area Health Authority (the second AHA). I have seen the relevant documents and correspondence from the files of both Authorities and the clinical and nursing notes relating to the complainant's husband and to Mrs A. My officers visited the hospital and discussed the complaints with the medical and nursing staff concerned with the husband's care and with the administrative staff there. They also took evidence from a consultant geriatrician and administrative staff of the second AHA and from the complainant and her husband.

(a) *The harassment*

4. In correspondence with the Secretary of State for Social Services and in discussion with my officer the complainant said that she had no complaint about the care and treatment given to her husband for the first four days after his admission. But when he was transferred to a mixed acute medical ward he was pestered by Mrs A, another patient on the ward. Before Mrs A directed her attention particularly towards the complainant's husband, he and his wife brought to the notice of the staff the unsatisfactory position arising from Mrs A wandering about the ward, but no action was taken. Subsequently, Mrs A caused the husband considerable distress and he and the complainant referred in particular to two incidents on successive days. On the first, Mrs A came behind the screening curtains when the complainant's husband had just used the commode. Since the call-bell on his locker was not working he had to shout for a nurse to come and take Mrs A away. The following day he was standing, undressed, beside his curtained bed, changing his ileostomy appliance when Mrs A again pulled back the curtains, causing him to be badly shocked and embarrassed. No sooner had he settled in bed than Mrs A once more approached him and he was obliged to get out of bed again and to shout for help. By this time he was hysterical and the complainant, who had just arrived to visit him, said she was appalled at the state in which she found him. As a result of the harassment by Mrs A, the complainant's husband said he became tense, tearful and nervous, and the complainant sought his discharge once the registrar had seen his x-rays. Even after his return home he had nightmares about Mrs A. The complainant said that the Consultant Physician responsible for the husband's care (the consultant) was away and she complained to his medical staff about the incidents, but they said that nothing could be done. Subsequently, she approached a member of the administrative staff (a principal administrative assistant (the PAA)) who arranged with the ward sister to move her husband's bed to another

position in the ward, since it was thought that Mrs A had some sort of obsession about the bed rather than about the occupant. The complainant also complained that the registrar had told her that as her husband had got over the first four days, stress was no longer important.

5. The first AHA accepted that the incidents involving Mrs A occurred as the complainant described them. The consultant, who was also responsible for the care of Mrs A, confirmed that Mrs A behaved in a confused and improper fashion and that her behaviour resulted in considerable disturbance to the husband's peace of mind. There was, he told my officer, no way of knowing the effect the incidents had on the husband's recovery but he said he would not willingly expose heart patients in his care to this type of disturbance. He thought that a formal apology to the complainant's husband was called for and I have seen that in fact it was included in the reply from the Department.

6. In discussion with my officer the Registrar agreed that he spoke to the complainant about the incidents involving Mrs A, and about her husband's condition, but he denied making the statement she attributed to him or saying anything that could be understood as implying that stress was unimportant. The Senior Nursing Officer (the SNO) said that the level of staffing was sufficient to run a busy, acute medical ward but inadequate to allow staff to follow Mrs A during her wanderings. She added that in the absence on leave of the ward sister she had received a telephone call from the complainant about the incidents. She discussed the case with the registrar and the PAA and they arrived at the solution of moving the husband's bed and giving him a locker with a call-bell that worked.

7. The complainant explained that she had in the past been a professional Social Worker and was still concerned with what she described as 'handicapped and geriatric/confused members of the public'. She said that she could not understand why Mrs A was not receiving any treatment. She added that if Mrs A had been sent to a psychiatric day-centre she would have been able to roam about under the supervision of appropriately trained staff. The complainant suggested other alternatives for Mrs A – care at a day-centre for the elderly run by the social services department, or care in a day-centre attached to a hospital, or care in a geriatric ward at the hospital.

8. The consultant explained to my officer that it was not their practice to use day-centres for hospital in-patients; they were intended to support people in the community, especially out-patients who had recently been discharged. Moreover, practical difficulties of transport, escorts and treatment routines militated against their use by in-patients. In the consultant's opinion Mrs A would not have obtained any benefit from reference to a day-centre. Furthermore, the geriatric day hospitals in the city did not take patients from the district of the city in which Mrs A resided. The medical social worker confirmed to my officer that it was not the practice to refer in-patients to day-centres because there were so many people living in the community waiting for places and day hospitals were used primarily by patients who had been recently discharged from hospital following treatment as in-patients.

9. The complainant suggested that Mrs A could have been transferred to a geriatric ward in the hospital, but I have found that Mrs A's place of residence

prevented this. The consultant said that geriatric beds at the hospital were for patients normally resident in one of the city's District geriatric catchment areas. The first AHA explained that the geriatric service in the city was originally developed at the hospital to serve the former County Borough only. Following re-organisation of the National Health Service in 1974 peripheral areas, which under local government re-organisation had been included in the Metropolitan District, were included within the boundaries of the first AHA, but the residents of those areas continued to receive geriatric care from other hospitals on the basis of their geographical location. Under these arrangements, although Mrs A's place of residence was included within the boundary of the first AHA, the hospital providing geriatric services to its residents was a general hospital ('the general hospital') which is within the second AHA.

10. I have seen that one of the objectives of the first AHA in their Strategic Plan was to provide geriatric services to their total geriatric population. By 1978 the first AHA were in a position to provide services to 81.9 per cent of their total geriatric population. Although neighbouring authorities have pressed the first AHA to assume total responsibility for the geriatric care of all elderly residents of the city, there is still a shortfall of beds on the target requirement to enable this to be accomplished and the first AHA are not prepared to accept full responsibility until these beds become available or until through-put of patients increases further. Plans to meet the shortfall of beds have been prepared but can only be implemented if development moneys become available or the Regional Health Authority (the RHA) agree to special funding arrangements. The priorities of the first AHA to achieve their objective have been agreed, although some reassessment might be necessary because the RHA take the view that extension of the catchment area to include part of the locality in which Mrs A lived deserves high priority.

11. The second AHA told me that since 1974 they had made repeated representations both to the RHA and to the first AHA that the latter should provide services to patients from the locality in which Mrs A lived, particularly geriatrics, within their own area. No satisfactory conclusion had been reached and the relevant District of the second AHA had to continue to provide beds and facilities from within its already limited resources for such patients; the District is some 40 or so beds under-provided in relation to the elderly population it has to serve. The second AHA said that patients from the locality in which Mrs A lived generally occupied 20–25 per cent of geriatric beds in the District and many others awaited admission. The Consultant Geriatrician at the general hospital was under continuous and extreme pressure to take more patients, many from the locality in which Mrs A lived, and services to their own patients were suffering under the arrangements.

12. The consultant responsible for the husband's care agreed with the complainant that an acute medical ward was not an appropriate place in which to nurse the elderly confused, but said that since Mrs A had been admitted as an acute case there was no alternative but to accept her, and having done so, to care for her until more appropriate accommodation became available. Against the background set out in paragraphs 8–10, I therefore examined the steps that had been taken at the hospital to transfer Mrs A from the acute medical ward.

13. I found that Mrs A, who was somewhat older than the complainant's

husband, had been admitted to the hospital as an acute case in January 1978. She was considered to be incapable of supporting herself at home and at the beginning of February the consultant's team decided, because of the location of Mrs A's home, to refer her for a geriatric bed at the general hospital. On 15 February they received a reply confirming that Mrs A's name had been added to the waiting list there. The consultant told my officer that Mrs A had not been seen by a geriatrician at either hospital but it was open to the geriatrician at the general hospital to arrange assessment before he accepted her on to his waiting list if he so wished. He said that, generally, she was very peaceful but wandered. He thought that she was encouraged in her wanderings by some male patients giving her sweets and biscuits. He did not think that she was attracted to the particular bed occupied by the complainant's husband. On 16 March (before the incidents in question) Mrs A was being considered for Part III accommodation. The Medical Social Worker told my officer that Mrs A was added to a waiting list for that accommodation early in April, but the waiting time was at least three months and could extend up to one year.

14. On 21 April the registrar got in touch with the general hospital and explained the difficulty they were experiencing in controlling Mrs A. The consultant told my officer that his team had done their best to control Mrs A but it was not easy when she refused to take medication. He added that there was no way in which pressure could be brought to bear for a transfer since it was a case of waiting for a bed to become available. On 10 May after Mrs A had pestered another very ill patient and following a discussion with a psychiatrist at the hospital, the consultant arranged for Mrs A's name to be added to the waiting list of a psychiatric hospital in a third AHA.

15. The Consultant Geriatrician at the general hospital, who has now retired, confirmed that doctors at the hospital had approached him about a place for Mrs A at the general hospital and that he had undertaken to admit her as soon as a bed became available. But he added that a patient who was already occupying a hospital bed elsewhere did not have the same degree of priority as patients awaiting admission from home where they could no longer be cared for satisfactorily. Mrs A was transferred to the general hospital in early September.

16. I have established that in March 1978 962 of the 1,004 available geriatric beds in the first AHA were occupied. There were also patients in hospitals awaiting transfer to the geriatric departments, including at that time 15 female patients.

Findings

17. The first AHA accept that the incidents involving Mrs A happened substantially as described by the complainant and the Department offered on their behalf sincere apologies when the matter was first investigated. The registrar denies that he made any remark which could have been taken as meaning stress was unimportant and I can only conclude that there was a misunderstanding between him and the complainant. The consultant said he would not willingly expose heart patients to incidents such as those that occurred in this case and I have no reason to doubt the complainant's allegation that they caused her husband considerable anxiety and distress.

18. The complaint about the behaviour of another patient in the ward led me to investigate the circumstances of her presence there and the case serves to illustrate the difficulties that patients and medical and nursing staff have to face when suitable resources are not readily available. Mrs A's name was added to lists for geriatric Part III and psychogeriatric hospital accommodation and although I cannot question that clinical judgment of the consultant or that Mrs A would have gained no benefit from a day-centre, it is very evident that the consultant did not consider her to be a suitable patient for a mixed acute medical ward.

19. Although Mrs A's name was on three lists I think it should have been apparent to the consultant that none of the accommodation requested would be immediately available. I have seen that there was a small number of unoccupied geriatric beds in hospitals within the first AHA at the time but that these were not available to Mrs A because of her place of residence. While I recognise the importance Area Health Authorities attach to adherence to catchment area policy, it seems to me that there may be occasions when more flexibility in approach would be in the interests of patients and staff alike. Had there been a little more flexibility in this case I think accommodation could have been found within the existing resources of the first AHA which would have been more appropriate than the mixed acute medical ward on which Mrs A remained for more than seven months. It is clear that Mrs A was wandering about the ward before the incidents complained of occurred and that the consultant's team had already concluded that a geriatric bed was more appropriate for her. This highly unsatisfactory situation was allowed to last for far too long. I am surprised to learn that Mrs A was not assessed by a geriatrician. Furthermore, Mrs A's need for transfer, apart from any clinical grounds, warranted priority consideration if only to put a stop to her known harassment of acutely ill patients on the ward. I believe that the distress the complainant's husband suffered could have been avoided. I uphold the complaint.

(b) *Nursing care*

20. When my officer spoke to the complainant and her husband they referred to particular details of the nursing care on the ward. They said that on one occasion, when the complainant's husband asked for a bowl of water to wash his hands after using a bedpan before the evening meal, he was asked by a nurse why he wanted it. On another occasion he asked the sister during the morning for an extra blanket but was not given one until after he had gone to sleep that night, when it was left at the bottom of the bed; the sister later said she had forgotten about the blanket. One evening about 8.00 pm he had asked a nurse for a mouth-wash since he was not supposed to leave his bed, but nothing happened and at 10.45 pm when he wanted to go to sleep he went to the hand-basin himself only to be reprimanded by a nurse.

21. There is no evidence in the nursing notes of any specific complaints about any of these matters and the ward sister told my officers she had no knowledge of any failure to provide a wash-bowl or a mouth-wash. She said that she did remember the complaint about the blanket although she said the request had not been made to her in the morning, because she was not on duty then. She admitted that when the complainant's husband asked her for it she forgot at the time and

placed it at the end of his bed later. The following day she apologised to him when he mentioned it.

Findings

22. Although the sister did not recall the incidents about the wash-bowl and the mouth-wash I have no reason to doubt that they occurred. The ward sister admits she forgot to give the complainant's husband a blanket when he asked for it. That was a human error for which she apologised the following day and I do not think that she could have done more.

Conclusions

23. Progress by the first AHA towards their declared objective of self-sufficiency in geriatric care has been hampered by the non-availability of resources. I cannot criticise them for maladministration on that account. I can do no more than encourage the first AHA and the RHA to implement their plans as quickly as possible. But given the situation as it exists it seems to me that co-operation between the Area Health Authorities involved and flexibility in their approach to the use of existing resources are matters of good administrative practice. The incidents which were the subject of the main part of this complaint caused the complainant's husband distress which I believe could have been avoided. Although Mrs A's name was added to three lists I do not see this action as the most positive response to the situation caused by her continued presence on a mixed, acute medical ward. I therefore invited the first AHA to consider whether this was an occasion when it would have been in the best interests of all concerned to adopt a more flexible approach towards the allocation of a bed for an in-patient who was clearly inappropriately accommodated. The first AHA replied that there was no doubt that a geriatric ward was the proper accommodation for Mrs A and they accepted that in future arrangements for patients with particular difficulties should be reviewed with greater speed. But they also acknowledged that the answer to the problem was in the first AHA becoming 'self-sufficient' as soon as possible and they have assured me that, subject to the constraints I refer to in this report, this is their objective.

Case No. W.11/79–80 – Failures in communication relating to the care and treatment of a spina bifida child

Background and complaint

1. The complainants' son, who was born in January 1976 and who suffered from spina bifida, underwent an operation for the correction of a dislocated hip in hospital (the hospital) in July 1978. He was in the care of a Consultant Orthopaedic Surgeon (the consultant). The complainants contend:

(*a*) that the consultant did not explain the exact nature of their son's operation, partly because he said they would not understand the technicalities of surgery; that they were not told that a report had been sent to their family practitioner from whom they could have obtained advice; that they were required to sign a consent to operation form without being given an adequate explanation; that the consultant's attitude to them was unhelpful and rude; and that the mother was

humiliated by the consultant when she asked him for a signature required to obtain a special 'pram';

(*b*) that they were not forewarned of the length of time their son would have to spend in a plaster cast or of the practical problems this would cause; and that conflicting advice was given to them by the consultant and nursing staff as to the care their son required in the 24-hour period between the removal of the plaster cast and its replacement with a splint; and

(*c*) that the Area Health Authority (the AHA) failed to deal adequately with their complaints.

Investigation

2. During the investigation my officer met the complainants and members of the medical, nursing and administrative staff of the AHA. I myself agreed to see the consultant at his request and I examined the medical notes and correspondence about the complaint.

(a) *The complaints that an inadequate explanation of the proposed operation was given; that they were not told they could get advice from their family practitioner; that no explanation was given when a consent to operation was signed and about the consultant's attitude*

3. In correspondence and when interviewed by my officer, the mother said that when she was told by the consultant that her son would need an operation on his hip she had asked him what the operation would entail. He had replied, in an abrupt and rude manner, that the operation was necessary but that she would not understand the technicalities of it. She said that her son had undergone several operations under another consultant at the hospital and on those occasions her questions had been answered and explanations given in terms she could easily understand. She said that as far as she had been aware the consultant was her only source of information about the operation. He had almost invariably seen her son at the hospital clinics and he had not told her that a report on his condition had been sent to his family doctor. If he had done so they could have obtained information from him.

4. The mother said that she had told a physiotherapist at a school which her son attended that she was worried because she had heard that, following a similar operation, another child's hip joint had locked with the result that he could kneel but not sit. The physiotherapist had explained that there were two types of operation, one which concerned the 'movement of muscle tissue' and the other 'grinding' of bone, and that it was the latter operation which the other child had had. The physiotherapist had suggested that she should write to the consultant on behalf of the complainants but when the physiotherapist was told who the consultant was she remarked that there was no point in writing as he would not reply to her.

5. The mother said that on the day her son was admitted for his operation, the consultant had examined him in the in-patient ward (ward A). After the examination he had walked away from the bed and explained to a number of medical students the operation he proposed to do. Although she knew it was

wrong, the mother said that she had followed the consultant and heard him describe the type of operation which involved the movement of muscle tissue. Shortly afterwards she was called to the sister's office in ward A where she was asked to sign a consent to operation form. Although no explanation of the operation had been given to her, she had signed the form because she had heard the consultant refer to the 'muscle' operation.

6. The mother said that the consultant's attitude towards her had been unsatisfactory throughout the period he had been treating her son and that he was very different in this respect from all the other hospital staff. They had not complained because they understood that the consultant was the expert in his field and they did not wish to do anything which might affect their son's treatment. However, after the operation an incident occurred (referred to in paragraph 17) which had caused them great anxiety and she had written to the Sector Administrator of the hospital (the SA) complaining about it. She had also referred to the consultant's attitude towards her and to the occasion when it had been suggested to her that she should ask the consultant for his signature on an application for a special 'pram' she required for her son and to his reply – 'I have more important things to do with my time, go and see somebody else' – she said that she had felt embarrassed and humiliated by the way he had treated her and that she had been afraid to ask him questions after this incident. She also complained that the consultant had refused to explain the nature of her son's operation to her, as in his opinion she would not understand the technicalities.

7. Shortly after she had made this written complaint, she said that she and her son attended an out-patient clinic and when she first saw the consultant he said, aggressively, 'Yes, I want to speak to you' and he had walked away. Later he returned and said 'Before we start I want to tell you this: if you have no confidence in me as a doctor, I refuse to treat —— any longer'. At that time, the mother said she was not aware that there was another orthopaedic surgeon who could look after her son and so she had been very frightened by the consultant's remarks. He had told her that it was her own fault that she had not been informed about her son's progress as it was up to her to ask questions. The mother said she had reminded him that when she had asked him questions he had told her that she would not understand the technicalities. The consultant's reply was 'Quite right'.

8. The consultant in his letter to the AHA and to my officer said that he had been very surprised that the mother had complained about him as his relationship with his patients and their parents was very good. He said that he made a point of keeping family doctors fully informed of their patient's progress as he believed it was important that there should be no loss of contact between the family doctor and his patient during hospital treatment. He told patients (or their parents) at his clinics to go to see their family doctors if they had any worries and he felt sure that he must have said this to the mother. If the mother had had any problems she could also have discussed them with other doctors on his team who were quite capable of dealing with these matters and would have been very willing to do so. The consultant said that there was a further opportunity for parents to obtain information: parents, in particular mothers, often spent afternoons with their children in ward A and if it seemed to the ward sister that

any parent was worried she was brought to see him in ward B, where he held his out-patient clinics, at the end of the session.

9. The consultant told my officer that in his letter to the AHA he had reiterated his complaints that the facilities provided in ward B were totally inadequate and of a low standard. It was very noisy and lacked privacy and he wrote that in his view it was not possible to go into the small details of medical management with the parents of each child in the 'often turbulent orthopaedic clinic and very difficult surroundings of ward B' and that 'in any event parents never really appreciate the technicalities of surgery'. Although he did not allow the clinic facilities to affect him they did in his view inhibit some parents in discussion. The consultant did not remember the incident when the mother said she asked him about the 'pram' nor had he been aware that she was worried about the surgical procedure to be employed in the reduction of her son's hip. The consultant agreed that although he could not remember being questioned about the proposed operation by the mother he might not have given her details as he would not have known with certainty at that time the method of reduction which he would need to use.

10. The consultant told my officer that it was the job of his house officers to obtain the consent to an operation from the parent and to provide the necessary explanations. He pointed out that the consent form given to the mother to sign had a very full description of the operation and said that the doctor who had signed the form confirming that he had given an explanation of the operation was a most conscientious doctor and that he would be most surprised if an explanation had not been given. The description of the operation on the consent form signed by the mother was 'STABILISATION (L) HIP BY CAPSULAR PLICATION & POSS. ILIO-PSOAS TRANSFER'. The former senior house officer, who signed the consent form, could not remember the mother or her son but he confirmed that it was part of his job to explain the nature of an operation before obtaining consent and he said that if he had signed the form then he would have given the explanation. He also said that in the complainants' son's case, a routine admission, it would have been unusual for the consent to be obtained on ward A.

11. The consultant said that his clinics at the hospital were always busy and as he believed it was in the best interests of patients as a whole that he should see as many as possible, he was not able to spend very much time with each of them. In his experience his relationship as doctor with his patient, or parents in the case of children, was very good; he agreed that there were occasional exceptions and that perhaps if the mother had seemed 'all tensed up' when they met he might have withdrawn a little. He could think of no other explanation for this complaint and he said he was however very sorry that it had arisen because he had been caring for the complainants' son for two and a half years.

12. My officer met the family practitioner with whom the complainants' son was registered and also another doctor in the practice who had been involved with the complainants and their family. They confirmed that they received reports about the complainants' son from the consultant and his registrar but they could not recall the complainants visiting the surgery to discuss them. In general they thought that patients were aware that such reports would be sent to family practitioners. They said that patients would usually arrange to discuss

such reports after they had been referred to hospital in respect of a new condition but not where they had attended hospital clinics on a regular basis for a known condition. The family doctors said that they themselves would not advise their patients of a routine report received from a hospital.

13. A sister who was on ward A when the complainants' son was a patient told my officer that it was a sister's responsibility to ensure that the consent to operation form was completed prior to an operation. It was, however, a doctor's responsibility to explain the nature of an operation and to obtain the parent's consent and the practice was for a house officer to complete the consent form with the parent on ward B and the form was then sent to ward A with the patient's case notes. She said that it would therefore have been most unusual for the mother to be asked to go to the sister's office on ward A to sign the form and, although she remembered the mother and her son well the sister was unable to recall this happening. The sister confirmed that she commonly arranged for parents of patients on her ward to see the consultant after his clinics at ward B. The Nursing Officer (the NO) also confirmed this procedure and said that as the consultant also worked in other hospitals and was accordingly very busy, parents usually saw his senior registrar but arrangements could always be made for parents to see the consultant if they so desired.

14. Towards the end of my investigation the consultant asked that I should myself hear his submissions about the case and I agreed to do so. In the course of a lengthy interview he explained to me how unsatisfactory were the conditions in ward B and how little conducive they were to entertaining requests from the parents of patients for painstaking and detailed explanations of possible or proposed treatment in these difficult and often tragic cases. I fully accept what the consultant told me about these conditions and I hope they may soon improve. I also accept that the unrestful atmosphere created by such conditions makes full and effective communication with patients and parents very difficult. Nevertheless, the consultant explained to me that where handicapped children were concerned, the parents themselves had to be considered as a clinical responsibility: 'It is the whole family one is treating'. He further observed that the reaction of parents to the production of a handicapped child is very variable. Some are comparatively resigned and accept their misfortune with fortitude. Others become 'hyperprotective' about their child and make heavy demands on medical and nursing staff, a reaction which the consultant described as 'very natural'. He pointed out to me that it was not practicable for him personally to give detailed explanations of operative procedures to every patient in a clinic where he would commonly see 30 patients, all with major disabilities, and anyway 'they could not really appreciate the technicalities . . .'. In the course of his submissions to me, the consultant explained concisely and with excellent clarity the nature of the complainants' son's problem and possible ways of dealing with it. I suppose it took about three minutes to do this. But the consultant also told me that the vast majority of his patients or their parents accept that the treatment given will be the best possible and are content to trust their medical advisers and not to seek more detailed explanations. Indeed, he indicated that the mother's demands were quite out of the ordinary. That being so, it is not the case that much additional time would be needed to give explanations to those parents who ask for them; at the most one is considering a few extra minutes with a very few patients. The consultant told me that he

invariably tells patients that he will be writing to their family practitioners with a full explanation of the results of attendance at his clinic and necessary details of proposed treatment. Whether or not the mother was told this, as to which I am not certain, it is in my view beside the point. Human beings in distress invariably seek out the highest point they can reach in the hierarchy which seems to them to be controlling their destiny. This is an entirely natural response, although I recognise that it cannot always be satisfied. I think that, in the light of the consultant's earlier observations to me about the need to treat the whole family and about the exceptional reaction of the mother to the distress of bearing a handicapped child, she was entitled to be told, briefly and in simple terms, just as I was, the exact nature of her son's problem and the possible ways of dealing with it. And she was entitled to be told this by the consultant himself in whose pre-eminently able hands the ultimate welfare of her child lay. But I am quite satisfied that she was *not* told these things by him, because he as much as said so himself, quoting his own words to her: 'You must trust me and leave it at that'. I do not think that in a relationship so intimate and vital as that between surgeon and patient, especially in serious illness, it is enough to use phrases such as: 'My registrar will explain things to you' or 'I will write to your family practitioner'. When a particularly anxious patient wants reassuring explanations from the surgeon who will himself operate, I think that he or she is within reason entitled to the time and effort necessary to give them, no matter how eminent in his field the surgeon may be nor how authoritative his clinical opinions.

Findings

15. I therefore find that in this case there was a failure which is open to criticism, although I think the mitigating circumstances are such that the failure is not a very serious one since the mother could without difficulty have obtained all the information she needed from other doctors in the consultant's team. But that, as I have said, is not really the point.

(b) *The complaints about the time the complainants' son was to remain in a plaster cast and the practical difficulties this would cause and the conflicting advice given about his care in the period between the cast being removed and a splint applied*

16. In her letters and to my officer the mother said that following her son's operation on 21 June 1978 he had been put in a plaster cast and remained on ward A; on 3 July the cast was replaced and shortly afterwards he was discharged home. She said that she had been told, she believed by a nurse on ward A, that her son would have to remain in plaster for 8–10 weeks, so when he went back to the hospital on 23 August she had fully expected that the cast would finally be removed. However, when he returned from the theatre she was dismayed to see the cast had again been replaced. She said that she had cried and become so upset that the ward sister took her to see the surgeon who told her that some tissues had not completely knitted and that the plaster must remain probably for a further 2–3 months. She said that she asked him what was the usual period in plaster after this type of operation and he had explained that this varied – he had known cases of six weeks but on the other hand he recalled a case where the period had been 12 months. The mother spoke of the difficulties she had had in looking after her son at home in his plaster cast. She said that

she was not complaining about the length of time he had to remain in the cast but that she could and should have been forewarned of the difficulties with which she would be faced when she took him home in the cast.

17. The mother said that on 11 October her son returned to the hospital and his cast was removed and she asked the sister on ward A if she could pick up her son but the sister warned her very emphatically that she must be careful as he was to be put into an abduction splint which would not be available for 48 hours. The mother said that she was worried about how she would be able to keep her son's legs apart until the splint was ready and she complained to the sister about the delay as she was afraid that his hip might again dislocate. As a result the sister arranged for the splint to be made available within 24 hours during which, the mother said, her son was either in his cot with his legs tied to the sides or held on the hip to keep his legs apart. The consultant had later said that 'there was no danger of the left hip re-dislocating in the short period between coming out of plaster and the application of any particular splint'. The complainants said that the task of caring for a child severely affected by spina bifida was exacting and demanding, that at the least parents should be given clear unequivocal and agreed advice from the hospital staff, and that they had been needlessly worried about their son.

18. The sister told my officer that she would not have specified the length of time that the complainants' son would have to remain in plaster as the period varied from patient to patient. She said that the mother had been very upset when her son returned to the ward with a new plaster and that she had taken her to see the surgeon so that he could give her an explanation as to why this was necessary. The sister said that she was surprised that the mother had complained that she was unprepared for the problems she faced when she took her son home with a plaster cast. She thought that the difficulties the mother encountered were those which a mother of average intelligence, which in her opinion she clearly was, would have considered. Like other mothers the complainant was often on the ward and talked frequently with the nursing staff. Her son was in the plaster cast which kept his legs apart and if she had had any fears there was ample opportunity to discuss them. Her own relationship with the mother had been very good and she would have been pleased to advise her if she had known that she was worried.

19. The sister said that when the plaster was finally removed the mother asked her if the legs were 'now all right'. As far as she could recall, because she knew that an abduction splint was to be fitted, she had told her that she must be careful to see that nothing was done to cause a new dislocation. It was possible, she said, that she may have exaggerated the risk to bring it home. She said that because the mother had been upset by the delay, which was normal, in providing the abduction splint she had taken action and reduced the waiting period to 24 hours.

20. In his reply to the complaint the consultant wrote: 'I cannot accept any criticism regarding the timing of coming out of plaster casts and I would certainly not be persuaded to put the child back in plaster to await the delivery of the abduction splint as such a procedure would be entirely unnecessary and expensive. I would stress further that there was no danger of the left hip re-dislocating in the short period between coming out of plaster and the application

of any particular splint.' The consultant confirmed this to my officer and added that splints were not immediately available because it was necessary to measure the individual child for one when he came out of plaster and also that there were occasions when it was found that splints were not necessary; it would therefore be wasteful to produce splints in advance.

Findings

21. I am satisfied that the mother was given the help the staff thought she needed and that supplementary advice was readily available should she have asked for it. The advice given by the sister to the mother about her son's care in the interim period between the removal of his plaster cast and the provision of the splint was given in good faith and in his interests although she admits that she may have exaggerated the need for care. She took prompt action to relieve the mother's anxiety. I do not uphold these complaints.

(f) *The failure of the AHA to deal adequately with the complaint*

22. The mother's letter to the hospital made the complaints I have summarised in sub-paragraphs 1(a) and 1(b) and said 'If the operation does prove unsuccessful my husband and I intend to take this matter further, as everything was all right until the plaster cast was removed'. After the mother attended the clinic at the hospital on 9 November when the consultant spoke to her about her letter of complaint (see paragraph 7), the father wrote asking for a meeting with the SA and the consultant to discuss the complaints. He said that his wife had tried to discuss them at the clinic but that the consultant had been rude, his general manner intimidatory and that he seemed more concerned with his professional competence being questioned than with the natural concern of the complaints for the health and wellbeing of their son. They also sent a copy of this letter to the Area Medical Officer (the AMO) enclosing copies of their correspondence on the complaint. The AMO told them in his reply that he would 'keep a personal eye on this enquiry, especially as part of your complaint is against [the consultant]. Medical matters such as this are, of course, my responsibility'.

23. The complainants said that the reply from the SA to their complaint had consisted of a letter from the consultant which refuted their complaints. They had been frightened by it because it referred to the possibility of taking legal action against them for what they had said. They had got in touch with their local Community Health Council (the CHC) who had helped with arrangements for the transfer of their son to the care of another consultant and had also arranged for them to see the AMO. Although, they said, they thought the AMO did his best to help them they were unable to obtain satisfactory answers to their complaints because the consultant was not present.

24. The SA, who has since left the hospital, said that on receipt of the complaint he had followed his usual procedure and asked the consultant for his comments. The consultant sent the SA a report (of which he sent a copy to the AMO) and asked the SA to ensure that it was sent unaltered to the complainants. The consultant added that he did not consider a meeting would have any useful result as he had nothing to add to his report. The SA expressed his doubts about the consultant's proposals to the area general administrator (the AGA)

but he was told that the then Chairman of the AHA (the then chairman) had said that the complaint was to be handled in the way the consultant suggested. This was not, he told my officer, the way he would usually have dealt with the complaint but in the circumstances he had no option but to carry out his instructions.

25. The AMO told my officer that he had received a copy of the consultant's report and that he had written 'excellently handled' on it. He had made this observation in the belief that the letter, which was marked 'private and confidential', was from the consultant to the SA to assist him in replying to the complaint. He said that he had not known of any intention that the letter should be sent to the complainants and if he had been consulted he would have had strong reservations about such an action. He had next heard about the complaint from the CHC secretary, and only then discovered that the consultant's letter had been sent to the complainants. His main concern thereafter had been for the continuity of their son's care at the hospital and to ensure that the complaints made against the staff did not affect this in any way. He arranged to meet the complainants with the CHC secretary but he had felt that the meeting did not satisfy them. He had therefore suggested that if they wished to pursue their complaints further they should put them to me. The complainants had, he said, asked for the consultant to be present at the meeting; he had discussed their request with the then chairman but they had decided that there was little merit in trying to persuade him to do so in the circumstances.

26. The AGA confirmed to my officer that the SA had expressed his misgivings about the consultant's proposal and that he had shared them. He had therefore spoken to the then chairman, who considered that the mother's letter contained an implication of negligence against the consultant and in the circumstances he felt that it would be wrong to deny the consultant the opportunity of having his comments conveyed verbatim to the parents and instructed that that should be done. My officer was unable to speak to the then chairman as he died shortly after my investigation began.

27. The consultant told my officer that he considered that the mother's letter contained a threat of legal action against him for negligence and he had therefore told the SA to send his letter unaltered because he did not wish the sense to be changed by omission or rewording. In his letter he dealt with the son's treatment and went on: 'I now come to her comments regarding the success, or otherwise, of surgery and the further statement, and I quote: "If the operation does prove to be unsuccessful my husband and I intend to take this matter further as everything was all right until the plaster cast was removed". This statement is an implication of negligence and I must at this juncture place my position very clearly in this matter. First, the whole tone of the letter is bordering on being libellous and I strong object to the implication. Secondly, if [Mrs———] is unable to trust us as a team future mutual co-operation will be impossible and I would respectfully suggest that I should withdraw my clinical supervision of the case. I must have in writing, therefore, from the family as to whether they wish me to proceed as I have done so to the best of my ability up to now. Finally, if [Mrs———] persists in the attitude which she has expressed in her letter I will have no alternative than to report the matter to my Medical Defence Union, who would act accordingly through their legal depart-

ment. My only concern in the care of any child under my supervision is to do the best for that child and [——] is no exception, but to do this efficiently I must have the trust of the parents. I am indeed very happy to continue to look after the boy; indeed, I did see him clinically with his mother at [the hospital] today. I have made my position quite clear to the mother. In due course, I await their further instructions.' The consultant told my officer that he thought he had acted quite correctly in the circumstance.

Findings

28. The complaint was directed primarily at the consultant and the SA acted correctly in obtaining his comments. I note that the consultant and the then chairman both felt that legal action might ensue but I consider that the decision to send a copy of the consultant's report under cover of a totally inadequate accompanying letter was ill-judged. Had the complaint related solely to clinical matters a suitable letter from the consultant might have been appropriate but the complaint included aspects involving nursing care and about the consultant's attitude; these matters were not investigated by the AHA nor touched upon in the reply. I uphold this complaint.

Conclusion

29. I have seen that the consultant devoted much of his great skill and valuable time to attending personally to the complainants' son. Yet I have found that there was a failure in communication between him and the complainants. And I have criticised the AHA's handling of their complaint. The AHA have asked me to convey, in this report, their apology to the complainants and I gladly do so.

Case No. W.86/79–80 – Failure to provide hospital bed following attendance at Accident and Emergency Department

Background and complaint

1. The complainant's 88-year-old father was taken by ambulance to the Accident and Emergency Department (the A and E Department) of a hospital (the hospital) on 19 December 1978 after a fall in his landlady's home. After treatment for a fractured clavicle and a head injury, the complainant's father was sent home. The following day he was seen by his family practitioner (the FP), who arranged for him to be taken by ambulance to the hospital again, but he was not admitted. The complainant was obliged to make arrangements for his father's admission two days later to a private hospital.

2. The complainant alleged that:

(*a*) on 19 December there was no transport available for a considerable time to take his father home after he was treated;

(*b*) the family could get no help from the hospital when they found they could not move their father to his bed that evening;

(*c*) on 20 December his father was given no help with dressing after the doctor had examined him and he had to wait for two or three hours for the ambulance wearing only a vest and rubber pants;

(*d*) although there were hospital beds available, his father was refused admission on 19 and 20 December; his children and the landlady could not look after him and it was impossible to make immediate alternative arrangements for private care;

(*e*) he was dissatisfied with the way in which the District Administrator (the DA) handled his complaint.

Investigation

3. During the investigation I obtained the comments of the Area Health Authority (Teaching) (the AHA(T)) and saw the correspondence and the medical and nursing notes. One of my officers, sometimes in company with another, discussed the complaint with members of the medical, nursing, and administrative staff at the hospital, and with the complainant's father's family practitioner and his partner, and also met his son, daughter and landlady. The comments of the Ambulance Service regarding the provision of ambulances were also obtained.

(a) *Lack of transport*

4. The landlady told my officer that she accompanied the complainant's father to the hospital after his fall on 19 December. They arrived at 5.30 pm and at 9 pm, after he had received treatment, the sister on duty in the A and E Department (the sister) told her that he was being discharged. When she asked about an ambulance to take them home the sister replied that they would not get any transport for three or four hours. From this reply the landlady gained the impression that she had no alternative but to make arrangements herself for transport home. This proved difficult as the telephones in the A and E Department were out of order and none of the taxi firms she eventually contacted could come immediately. In the end a friend drove them both home but it was difficult for the two of them to manage the complainant's father and he collapsed on the pavement as they got him out of the car.

5. The sister could remember nothing about the patient's visit to the hospital. She confirmed, however, that it was her practice to inform patients about the very long delays facing them when waiting for ambulances and she thought it possible that she could have mentioned a three-hour wait. Patients were usually grateful for the warning and managed to make alternative arrangements but if a patient still wanted transport she would arrange it. The Nursing Officer and other members of the nursing staff confirmed that patients did have to face delays in getting home by ambulance and that it was common practice to warn patients about this.

6. The Ambulance Service confirmed that no ambulance was requested to take the complainant's father home that evening. No statistics are maintained about waiting times for post-accident cases. They told me that there was no indication of any local problem on the evening in question although from 9 pm onwards the service was manned for emergencies only and cases such as this would have had low priority. Nonetheless, it should not have been too difficult to provide transport at 9 pm on a Tuesday evening.

7. The sister on duty on 19 December explained that when the public telephones

were out of order, relatives and friends could seek the assistance of the receptionist and I have seen that the landlady in fact did so.

Findings

8. There was transport to take the complainant's father home after treatment although it is impossible to say how long he would have had to wait for it. The sister relied on previous experience when telling him and his landlady about the delay they were likely to experience. But no member of the nursing staff attempted to get in touch with the Ambulance Service to see whether an ambulance could be provided within a reasonable time for an 88-year-old patient who had just been treated in the A and E Department. That, in my view, was an omission deserving criticism. Furthermore it is clear that there was some misunderstanding between the sister and the landlady as a result of which the latter was left to make arrangements for their return journey. Although I see merit in warning patients that there may be delay in getting an ambulance, staff should exercise caution in how they explain this to patients and make it quite clear that if the patient's condition warrants it, an ambulance can be provided.

(b) *Lack of help from the hospital*

9. The complainant's sister explained that her father's condition was such that she, her husband and the landlady were unable to get her father upstairs to bed at about 11 pm on 19 December. She sought help by telephoning the hospital direct only to be told politely that it was not something they could deal with. She did not know to whom she spoke and she was given no information on who might help her. The complainant's sister thought that in the circumstances her father should have been admitted to the hospital.

10. Understandably no records of such calls are retained but the consultant in charge of the A and E Department (the A and E consultant) told my officer that the call would probably have gone to his Department at that time of night where it would have been answered by any one of the staff. He explained, however, that the hospital could not reasonably be expected to take responsibility for people in their homes and in such circumstances relatives should get in touch with the family practitioner or, if appropriate, the ambulance service by way of the emergency services.

Findings

11. I accept that the hospital could not help when the complainant's sister telephoned and that it was not their duty to do so. However, I think the hospital should have explained how she might get help (see paragraph 10).

(c) *Failure to dress the complainant's father*

12. In discussion with my officers and in correspondence the complainant explained that he accompanied his father on the second visit to the A and E Department during the afternoon of 20 December. He said that after an examination by a doctor his father was left wearing only his vest with a blanket wrapped around him. His father's rubber pants were halfway down his legs but when he asked a nurse to help dress his father she said that the staff were too busy for anyone to help him. Consequently the complainant's father was obliged to wait

in this state for some two to three hours until the ambulance took him home. Although his father was quite warm and he acknowledged that the A and E Department was extremely busy, the complainant felt that someone might have been spared to help his father dress and to make his wait more dignified and comfortable.

13. My officer traced and interviewed all except one of the nursing staff who were on duty that afternoon but none could recall the events complained of. The sister in charge of the A and E Department on that day (the second sister) was, however, particularly surprised by the complaint because, she said, dressing patients was an integral part of the nursing role and usually took place while the patient was still in the examination cubicle. Neither she, nor any of the trained nurses to whom my officer spoke, thought that any of their colleagues would refuse help outright although all could imagine circumstances where the complainant might have been told that the nurse would return after completing another more urgent task. Two of the student nurses separately told my officer, however, that if relatives were on hand they might well be asked to help dress a patient, particularly if the nurses were busy and the A and E Department was short-staffed.

14. The roster for the afternoon of 20 December shows that there were eight nurses on duty, including the nursing officer responsible for the A and E Department (the NO), the second sister, who worked regularly in the Department, and a charge nurse who was providing relief cover. The remaining staff consisted of four students and a pupil nurse whose work would require the supervision of trained staff. At 5 pm they were joined by a part-time staff nurse. The A and E Department register records that 45 patients arrived for treatment between 11 am and 3 pm on 20 December.

Findings

15. I have been unable to identify any nurse who recalls being approached by the complainant for help but I think from the evidence of the two student nurses that the complainant's father might well have been left less than fully dressed. I do not doubt that the complainant sought the assistance of a nurse and I accept that it is not always possible for them to respond immediately to such a request. On this occasion, however, the nurse did not return to the complainant and I consider he was justified in complaining to me. But I am also surprised that the son did not renew his request for help, given the time he waited for an ambulance.

(d) *The failure to admit the patient to hospital*

16. The complainant contended that his father should have been admitted to the hospital. He believed that the FP and the district nurses who attended his father at his lodgings were of a similar opinion. He said that even though there may not have been any geriatric beds available he should have been admitted for one night, if only for observation. On 20 December when he himself accompanied his father to the hospital, he was astonished that his father was not admitted after the FP had taken the trouble to telephone the hospital and to write a letter which accompanied the patient. The complainant was unable to arrange for his father to be admitted to any of the nursing homes on the list which the Casualty Officer obtained from the hospital social worker and he

said that he, his sister and the landlady were unable to care for a man in his father's condition. In the event, his father returned to the landlady's home for the night of 20/21 December, in the course of which he fell out of bed and suffered considerable pain. The complainant arranged for his father to be admitted to a private hospital on 22 December but because of the expense he and his sister still hoped to get their father admitted to the hospital. Subsequently he was transferred to a nursing home and on 16 January was admitted to a geriatric bed in the hospital where he died on 26 February.

17. The casualty officer who examined the complainant's father on 19 December could not remember the case but, after examining her medical notes, said that it was obvious she had never even considered keeping him in hospital over the night of 19/20 December. She told my officer she would have had no detailed knowledge of the availability of beds and her own decision on whether or not the father's condition required admission depended entirely on her own clinical judgment. Had she thought that his condition did require it, she would have contacted the duty registrar of the appropriate 'firm' and it would have been for him to deal with the separate question of the availability of beds. I have seen that the clinical notes for that day include a reference to the effect that the complainant's father was conscious and orientated. But there is no reference in the notes to other conditions from which he was suffering, not related to the fall, which the complainant brought to my notice.

18. A different casualty officer (the second CO) examined the complainant's father on 20 December. He has since gone abroad but he wrote to tell me that he did contact the geriatric team, only to find that there were no beds available. He said that he did not consider the complainant's father a suitable case for one of the limited number of general medical beds available and added that the orthopaedic registrar (the registrar) to whom he spoke refused to admit the father to an orthopaedic bed. I have seen that the clinical notes for 20 December include the entry 'DW – discussed with – [named Registrar] – he will not accept him'.

19. This registrar could not remember being asked to admit the complainant's father and said that because 20 December was a Wednesday he would not have been on duty. Had a casualty officer contacted him, he said, he would have explained that he could not admit anyone as he was not on duty that day. Moreover, he always examined patients before deciding whether or not to admit them and recorded his decision in the medical notes. There is no such annotation in the notes.

20. The A and E consultant confirmed that the availability of beds was not an issue on 19 December. But he thought that on the father's second attendance the second CO's decision did rest upon the availability of beds. There were no geriatric beds available and in his opinion the father's injury was not of the kind which would have prompted the orthopaedic department to admit him to one of their beds. Although there were no special instructions concerning patients who returned to the hospital after a short interval, anyone coming to the A and E Department with a letter from their family doctor had to be seen by a senior hospital doctor. In such circumstances, he said, casualty officers referred patients to one of the registrars. Neither of the casualty officers who examined the complainant's father on 19 and 20 December was aware of this practice.

21. The A and E consultant is reported by the District Administrator in his letter of 1 June 1979 as expressing the view that, on the basis of the information contained in the complainant's correspondence and on the evidence of the photograph provided by him, the complainant's father should have been admitted. In that context the consultant admitted to my officer that there had been a failure in a service provided by the hospital. The Consultant Physician to the Geriatric Service (the consultant physician) at the hospital agreed with the view of his colleague in that he too considered that the lack of beds constituted a failure to provide a service. He said that the geriatric team had not been involved in the decisions on 19 and 20 December not to admit the complainant's father, but that there were in any event no geriatric beds available on either day. There were, however, other beds available but his colleagues were often reluctant to admit cases without significant orthopaedic injuries to them, and he himself considered it an unsatisfactory policy from the point of view of patient care to admit patients to any available bed. In his opinion the complainant's father was a geriatric case with an orthopaedic problem for which he required geriatric rather than orthopaedic care. The consultant physician also told my officer that he had visited the father after he had been admitted to a private hospital and saw that he was being well cared for there. When he was transferred to a nursing home the consultant physician was concerned that he would not receive appropriate care outside a hospital and decided to admit him.

22. The FP confirmed that he was acutely aware of the pressure on beds at the hospital and would never send a patient there who, in his opinion, did not merit admission; he said that his letter (which I have seen) and telephone call to the hospital reflected that view.

23. On the male orthopaedic ward, 21 of the 22 staffed available beds were occupied on 20 December. All 32 staffed available beds on the geriatric ward were also occupied. I have seen however that there was a small number of unoccupied general medical beds on both 19 and 20 December.

Findings

24. On 19 December the casualty officer decided that the complainant's father required treatment in the A and E Department only before returning home. That was a decision she took in the exercise of her clinical judgment and I cannot question it. But on 20 December it is apparent that the second casualty officer did consider whether the father should be admitted. Two consultants have subsequently admitted that there was a failure to provide a service in refusing admission. Further, although the clinical notes record that the second CO discussed the case with an orthopaedic registrar the latter has serious doubts whether he did so. The second CO decided himself that the case was inappropriate for a general medical ward. I find that on 20 December the complainant's father was examined solely by the duty casualty officer; this does not accord with the practice the A and E consultant told me should have been followed. It is a matter for concern that neither casualty officer was apparently aware of the procedure whereby a more senior member of the medical staff is required to see a patient when he or she brings a letter from the family practitioner. There was clearly a failure in communication between the A and E consultant and his staff in this respect. I uphold this complaint.

(e) The handling of the complaint

25. The complainant said that although he put his complaint to the hospital on 4 January and telephoned subsequently he did not get a reply from the DA until 27 March. In that reply the DA said among other things that there were no suitable beds available on 19 or 20 December. But the complainant was suspicious about this because he understood that one of the consultants had been unable to agree the contents of a draft reply. He therefore wrote to the DA again on 11 April asking how many non-geriatric beds were empty on the days his father was seeking admission; whose opinions the DA sought regarding the question of his father's non-admission; and what was hospital policy regarding elderly patients who required admission but for whom no beds were available. The complainant sent a reminder on 25 May and the DA replied on 1 June. The DA apologised for the delay and explained that he was dissatisfied with the way his department had handled the complaint. He also said that both the A and E consultant and the District Community Physician (the DCP) felt that on the evidence the complainant had provided, the father should have been admitted at least for an overnight stay. The complainant was dissatisfied with the DA's reply because the questions he put in his letter of 11 April remained unanswered; he was also unable to accept the DA's assurance that his enquiries had been thorough. He then wrote to me.

26. The DA told my officers that he delegated responsibility for obtaining and co-ordinating information and replies to complaints to the District General Administrator (the DGA) and his staff. I have seen that on 5 January the DGA acknowledged the complainant's letter and wrote to the A and E consultant, the consultant physician, the district nursing officer and the principal social worker, enclosing copies of the complaint and asking for their comments. By 29 January these had been received from both consultants and the principal social worker, while the district nursing officer had obtained a statement from one of the A and E Department sisters. The complainant enquired about progress and on 1 February was told that he should receive a reply within two weeks. The statement from the second sister was sent to the DGA on 19 February. The A and E consultant and the district nursing officer approved the draft reply to the complainant but the consultant physician felt unable to do so, pointing out that he did not approve of information being kept from relatives and although there were no geriatric beds available, there were 18 spare medical beds. Meanwhile the complainant had telephoned again on 5 March when he referred to his father's death. This event prompted the revision of the draft reply. The complainant telephoned again on 22 March and the DA replied on 27 March. His letter outlined the pressures on the hospital due to the closure of neighbouring hospitals and said that there were no suitable beds available on either 19 or 20 December.

27. Following enquiries into the three questions which the complainant posed in his letter of 11 April (paragraph 25), proposed answers were included in a draft reply. However, the DCP thought the tone of this 'too bureaucratic' and the DA agreed that it should not be sent. There then followed the complainant's letter of 25 May and the DA's reply of 1 June.

28. The DA told my officers that although there were some extenuating circumstances and the DGA's office was under considerable pressure at the

time, these did not provide any excuse for the delays and he was most dissatisfied with the way the complaint had been handled. There had been subsequent changes in the procedure for handling complaints (although not directly as a result of this complaint) whereby the district management team exercise a greater supervisory role. His eventual reply to the complainant did not reflect any conscious decision to withhold the figures of available beds. Rather, he felt that it was a matter of clinical judgment whether the complainant's father was admitted and, therefore, the question of availability of beds was irrelevant. While with hindsight various members of the medical team felt that he should have been admitted, the clinical judgment at the time was that he did not need admission.

Findings

29. I accept that various members of the staff responsible for handling complaints were working under some pressure. The DA himself had covered the work of the sector administrator for the preceding twelve months and continued to do so until July 1979. The DGA's office too was short-staffed due to periods of sick, compassionate and study leave taken by members of staff in the relevant period. Nevertheless, I consider that the delays in replying were excessive and the DA has accepted that the complaints were badly handled. I am glad to note that changes have been made in the method of monitoring and handling complaints.

30. Although the DA's first reply was a sympathetic one based properly upon the comments of the relevant medical and nursing staff it did not answer all the points made. It was also regrettable that the second reply did not answer the complainant's three questions. One of these dealt with the number of non-geriatric beds that were unoccupied on 19 and 20 December which might have been suitable for the complainant's father. Although the consultant physician mentioned 18 (paragraph 26), half of these were for patients suffering from rheumatic or skin conditions and I have been told and accept that they are not suitable for emergency admissions. Nevertheless I think some reference to the number of unoccupied beds should have been made in the DA's reply of 1 June. The DA took the view at that time that the number of beds was irrelevant (paragraph 28) but so far as 20 December was concerned, in the light of the evidence I have obtained, I do not think that view was a right one. I have however found nothing to support the complainant's fear that the approach of Christmas influenced the decision not to admit his father.

Conclusions

31. The complainant's father's family could not reasonably have expected to get assistance from the hospital on the night of 19 December when they telephoned. But I have upheld the remaining complaints. As regards the main one, two consultants have admitted that there was a failure to provide a service when the complainant's father was not admitted to the hospital on 20 December; when that decision was taken, the appropriate procedure was not followed (or even known) by the casualty officer and I regard this as a serious matter. The AHA asked me to convey on their behalf their sincere apologies to the complainant's family for this and the other shortcomings I have set out in this report. This I am pleased to do.

32. The investigation has emphasised the shortage of geriatric beds in the hospital – a situation which I have found all too often in other cases. I am pleased to report therefore that the consultant physician has subsequently been allocated a further thirty beds which is a step towards the improvement of facilities for the care of the elderly in the complainant's locality.

Case No. W.93/79–80 – Hospital transfer of elderly patient prior to death

Background and complaint

1. The complainant's father, aged 81, was admitted to hospital (hospital A) on 27 October 1978, following a fall down some stairs. At the time he was staying with his daughter although he was the tenant of a council flat in another county some 40 miles away. On 22 December he was transferred to a long-stay geriatric bed at another hospital, nearer to his flat (hospital B) where he died on 9 January 1979.

2. The complainant said that:

(*a*) she was not told of her father's medical condition or the prognosis for him until 18 December;

(*b*) although she was given assurances that reasonable notice would be given of any transfer, she was not told of the proposed move to hospital B until 18 December;

(*c*) the consultant geriatrician at hospital A (the geriatrician) refused to accept her father into one of his geriatric beds and refused to discuss the matter with the complainant;

(*d*) despite efforts to defer the transfer for a limited period while she attempted to make alternative arrangements for her father, and despite the availability of hospital beds staffed but vacant within the district, her father was sent to hospital B, more than 40 miles away, three days before Christmas; and

(*e*) the transfer itself was made without proper regard to his condition or the weather at the time.

3. The complainant complained through her Member of Parliament to the Minister of State at the Department of Health and Social Security (the Department) and directly to the Area Health Authority (the AHA) but was dissatisfied with their replies.

Investigation

4. In the course of my investigation I have seen relevant papers from the AHA and from the Area Health Authority in whose area hospital B lies. One of my officers, sometimes in company with another, met and discussed the complaints with members of the medical, nursing and administrative staff involved at both hospitals. My officers also met the complainant, her husband and a County Councillor who was a former member of the AHA, and who assisted them in their efforts to keep the complainant's father in the locality.

5. In the correspondence about the case and in discussion with my officers the complainant explained that she had endeavoured since 1976 to move her

parents nearer to her because of their age. When her mother died in hospital A in April 1977 the accommodation they were awaiting could not be made available to her father alone and she had to seek alternatives such as an exchange of council flats. Although her father wanted to retain his flat in order to maintain his independence, he was entirely on his own there and more at home with the complainant and her husband where he came to spend about half his time.

(a) *Communication over the father's condition and future*

6. The complainant and her husband told my officers that before 17 November when the county councillor took up their case they were told on separate occasions by two nurses and the house officer to the consultant physician caring for the complainant's father (the physician's HO) that, since the father was a resident of a different county, he would have to go back there if he needed long-term care. On one occasion during that period the physician's HO told them that the complainant's father was not fit to be moved and on another that he had had a heart attack or a stroke. They were given no other detailed information about his condition or prognosis until the senior house officer to the consultant physician (the physician's SHO) told the complainant on 18 December that her father had suffered a heart attack, there had been no improvement, he was incontinent and he would never walk on his own again or be able to care for himself; but that he was fit to make a two-hour ambulance journey to the other county where a bed was available for him. The county councillor said that, had the complainant known of the prognosis earlier she would have arranged to vacate the flat there; as it was, however, she proceeded on the basis of an exchange to the locality, knowing that her father would need to be near her if he were to be discharged. The complainant also wrote to various organisations with a view to raising funds for private nursing accommodation locally should the need arise. Without specific details of her father's condition, she said, she could not make firmer arrangements. She added that it distressed her that she was given no say in the decision on her father's future, even though he was unable to act for himself and she was his only relative and next-of-kin.

7. I have seen from the contemporaneous medical records that the complainant's father was admitted by the Accident Centre and two days later was transferred to a medical ward under the care of a consultant physician (the physician). He remained in the physician's care for the remainder of his stay at hospital A. The nursing notes record that a staff nurse on the medical ward (the staff nurse) on 9 November discussed the situation with the complainant and her husband who expressed their willingness to help if the complainant's father became more mobile; they could not afford private nursing care but wished to keep him in the locality. On 10 November an occupational therapist recorded her opinion that he was poorly motivated to become independent and recommended him for long-term care. On 15 November the physician's HO recorded that he had spoken to the complainant and her husband who were keen to move the father to their own area and he suggested they raise the matter with the social worker. The following day the medical social worker (the MSW) sent a report to the geriatrician stressing that the complainant and her husband were very anxious to have the complainant's father transferred to the area for long-term care as they were his only relatives. The MSW said that she had told them that it was most unlikely he could be admitted to a geriatric bed locally but

they were unwilling to accept this. She had suggested to them that they contact the geriatrician to discuss the problem.

8. A telephone enquiry from the county councillor on 17 November prompted the district administrator (the DA) to ask the sector administrator (the SA) to see if there was any possibility of long-term care for the complainant's father in the area. The SA made a note that the physician's HO told him that the complainant's father would always be incontinent, would not recover sufficiently to go to a convalescent home and would need permanent nursing care and that he, the HO, had conveyed this information to the complainant. On 20 November the physician's SHO wrote to a consultant geriatrician in the complainant's father's home county asking if he could 'make any offer [of a bed] on [the father's] behalf'; she said he no longer needed to occupy an acute medical bed but was aged 82, 'incontinent and really unable to cope on his own'. On the following day the locum geriatrician examined him: she thought he was not a good candidate for rehabilitation and said that, as he was not a resident of the area, he was not eligible for a long-term care bed. On 24 November the SA explained to the complainant, over the telephone, why a long-term bed in the area could not be offered and suggested, in view of her talk of convalescent homes, that she should ask the doctors on the ward about his condition.

9. In a statement dated 26 January 1979 the staff nurse confirmed that on 9 November she had discussed the father's needs and future care with the complainant and her husband who agreed that he could not be cared for at home in his condition at the time, ie incontinent of urine, unwilling to eat or drink and requiring two nurses to move, lift and assist him to walk. She added in discussion with my officers that she spoke to the complainant and her husband more than once about the possibility of caring for the father at home. The physician's HO told my officers that he spoke to the complainant and her husband on a number of occasions and because it was planned to move the complainant's father to the other county, he arranged a specific appointment to discuss with them the diagnosis and the difficulty of arranging long-term care in their county area. He said he would have told them first that the complainant's father would need rehabilitation; it was possible that he would improve; but quite impossible for him to go home at that time. He had also told them that they would be informed when a bed in the other county became available. They were upset and unhappy and he agreed therefore to ask the geriatrician to see the patient. The HO did not recall giving the complainant and her husband an explicit statement of the long-term prognosis.

10. In discussion with my officer the physician's SHO recalled that she spoke to the relatives about the father's condition immediately before he was transferred and was sure that the physician's HO had done so previously because the relatives were constantly trying to ensure that he was not transferred to his home county. In her view it was unreasonable for the complainant and her husband to say that they did not know his condition or the sort of care he needed; they were aware of his deafness, confusion and incontinence, and were unable to care for him at home because of his condition. The physician commented to my officers that he had not met the relatives nor been present when his doctors did so but he was sure they would have told them the truth. The SA confirmed to my officers the details of his telephone conversations and said that

he and the complainant both knew that the doctors were waiting for a bed in the other county.

Findings

11. I am satisfied that there was discussion of the father's medical condition between the medical and nursing staff on the one hand and the complainant and her husband on the other. I am satisfied that his daughter and son-in-law were aware of her father's deafness and confusion; the nursing notes and the HO have shown that the complainant and her husband expressed views on the use of catheters which suggests to me their awareness of her father's incontinence. It seems to me that the complainant should have realised, by the time the county councillor took up her case in mid-November, that her father's condition was such that she would be unable to look after him and that long-term care was needed. I am satisfied that the complainant knew sufficient details about her father's condition to have been able to approach nursing homes or pursue any other alternatives she may have had in mind, if she had thought it appropriate to do so. In fact she did. The physician's staff were not prepared to express an opinion on the prognosis of his illness but I do not believe that that affected the complainant's course of action.

(b) *Assurances of reasonable notice*

12. The complainant and her husband contended that they should have been given longer notice of her father's transfer, given the terms of the DA's reply of 29 November and the assurances he gave to the county councillor in the course of a telephone conversation the same day. The complainant referred my officers to a letter she wrote to the DA on 28 November expressing great concern about the plans to transfer her father to his home county as soon as he was well enough. She asked for some assurance that he would not be moved to the other county where he would be isolated from his only relatives, before she had time to see if she could make some alternative arrangement for him in her locality once he was well enough to leave hospital. In his reply the DA said that he could do little more than acknowledge the complainant's letter at that time because he knew that the SA was in close touch with the medical team about the possibility that her father might require admission to a geriatric ward after he recovered a little. Should such a decision be made, the DA said, the complainant should appreciate the very great difficulty the district had in providing facilities for the elderly; but he was sure the fact that her father had no other relative in the other county would be a factor that was taken into account, and he thought it very reasonable that the complainant would wish to explore any possible alternatives for the care of her father in her own county to avoid his being isolated. The DA said he would ask the SA to bring the complainant's letter to the attention of the doctors concerned.

13. In her notes on the complaint submitted to the AHA, which she confirmed in discussion with my officer, the county councillor said that while the DA was unable to confirm that the complainant's father would be kept in the District should he need more permanent hospitalisation, he felt any decision was premature. He did not think the complainant realised how seriously ill her father was. The county councillor said that the DA assured her that if a decision

to move the complainants father was taken then notice would be given to enable the complainant to see whether she could make private arrangements so that her father need not be transferred out of the county. The county councillor said she was told that she, too, would be informed when a decision was taken. As a former member of the AHA, she was sure the DA would not have given such an assurance without first consulting the medical staff. In view of what she had been told, she had told the complainant that there was no need for her to worry too much at that time and although the complainant and her husband continued to make enquiries they did not treat them as a matter of urgency. She added that in these circumstances it was very distressing for the complainant to be told on 18 December that a transfer was arranged to take place in two days' time and she felt that they had both been misled by the assurances.

14. In discussion with my officers the DA said he remembered speaking to the county councillor several times about the case and on one occasion, presumably 29 November, talking in terms consistent with those of his letter of the same date to the complainant. He could not remember his precise wording but believed he said that he understood the relatives wanted to look for accommodation and that that would be considered by the medical staff. The DA expected the complainant and her husband to start looking for accommodation locally as a result of his letter and thought that the county councillor's interpretation of his words might have been more optimistic than he intended. The DA said he hoped that the medical staff to whom copies of the correspondence were sent via the SA would honour what was said in the reply to the complainant. He said he did not know of the transfer arrangements until the county councillor telephoned him on 19 December. He arranged a two-day postponement of the transfer but the medical staff would not agree to one week's notice because they feared that the bed at hospital B might be lost. The DA thought that four day's notice was adequate for discharge from a medical bed unless the relatives had to find accommodation from the date of notification, but in any event his view was that the complainant and her husband had had since 29 November at least and that was really as much as they could expect.

15. The SA said in evidence to my officers that when the DA asked him on 29 November for details of the case in order to reply to the complainant, he told him of his discussions with the physician's HO and said that he had spoken earlier to the locum geriatrician who would only consider taking the complainant's father for a period of rehabilitation if there were some improvement in his condition. He told the DA that the medical staff were still planning to transfer the complainant's father to the other county. He understood the DA's letter to say only that it was reasonable that the complainant should want to explore all the possibilities; but the SA recalled thinking that the medical staff had made up their minds and there was not much that could be done. Nevertheless he copied the exchange of correspondence to the physician and to the locum geriatrician. The SA thought that the length of notice finally given was sufficient, since in view of his condition it made little difference to the complainant's father where he was, and the complainant would not have found a nursing home prepared to accept him whatever length of notice she received.

16. The geriatrician told my officers that he remembered having seen the correspondence but did not know if it had been taken into account by the

physicians who were responsible for the transfer arrangements. The physician said he took the view that the complainant had a month in which to find alternative accommodation and that was sufficient. The physician's SHO said that she did not see the correspondence but knew that the complainant and her husband were aware of the transfer proposal.

Findings

17. In his letter of 29 November to the complainant the DA referred to the possibility of the complainant's father requiring admission to a geriatric ward and that he thought it very reasonable that she should wish to explore possible alternatives in her own county. She was encouraged by this to believe that the transfer was still undecided and that she still had good time to explore alternatives. I cannot now determine exactly what was said to the county councillor by the DA but he agrees that it was consistent with what was said to the complainant in his letter to her. It has not been disputed that he also told the county councillor that he would inform her when a decision about the complainant's father's future had been made. I have no doubt that the county councillor was encouraged to think that time was not of the essence. By 29 November, however, I have seen that the decision that the complainant's father required a long-stay bed had already been taken, that the locum consultant geriatrician had said that such a bed could not be found for him in the district, and that the physician's SHO had already asked a consultant geriatrician in the other county if he could offer one (paragraph 8). In these circumstances the DA should have encouraged the complainant to pursue her enquiries urgently.

18. I have seen that on 18 December the consultant geriatrician at hospital B offered a bed there and that the complainant was told the same day. The complainant passed the information to the county councillor and it was from the latter that the DA learned the following day of the proposal to transfer the complainant's father. Given the communication with the DA that both the complainant and the county councillor had had at the end of November on the subject of the transfer, I can well understand their concern when they discovered that he was unaware of the arrangements that had been made by the physician's team. There was clearly a breakdown in communication here and I uphold this aspect of the complaint.

(c) *Refusal of a geriatric bed*

19. In correspondence with the AHA and in discussion with my officers the county councillor said that, although strictly the complainant's father might have been said to have been a 'resident' of the other county, after his wife's death that ceased to be absolutely true. She stressed the complainant's attempts to move her father to her own county and the ever-increasing amount of time he spent with her. The county councillor felt it was unfair to take account of the address of the father's family practitioner in deciding that he was a permanent resident of the other county because he had not needed a doctor's attention while staying with his daughter prior to his fall. She knew of no rule which required patients to be sent back to the area in which they were last registered with family practitioners if they fell ill in another county. In the county councillor's view, if it was the policy not to accept for long-term care patients from other

areas, then in this case that policy was too rigidly enforced; it was known that his only relatives lived locally were trying to find a home for him in their own county and, bearing in mind that he himself was deaf and often unaware of what was happening, it was unreasonable not to accept him there. The county councillor thought that the difficulty had arisen partly because the complainant and her husband lived in a part of the county which at the time was not strictly within the district's catchment area.

20. The AHA have told me that in 1978 the population of the catchment area served by the district's department of geriatric medicine was estimated at 27,500 aged 65 and over; in addition some 2,000 elderly patients from an adjacent health district looked to the department for health care. On the basis of the Department's recommendations on the number of geriatric beds to be provided the department of geriatric medicine should have had some 295 beds in December 1978; in fact 227 beds were provided, and 36 of these were in the process of being closed. The Department told my officer that they regarded it as important that long-term care for the elderly should be provided as near as possible to the patient's family and friends, but they accepted that ultimately the allocation of beds was entirely at the discretion of authorities through their consultants.

21. The district's admission policy for elderly patients was defined in January 1979 in response to a report by the Health Advisory Service on services for the elderly in the district. The policy states, *inter alia*, that patients with medico-social problems are usually referred to the geriatrician; patients having chronic problems are usually catered for by the general practitioner or by the geriatrician calling on his support services as appropriate. Chronically ill geriatric in-patients are cared for, in the main, by the geriatrician who controls all the long-stay geriatric beds. Elderly patients requiring consideration for admission to hospital in the district for an acute or acute-on-chronic condition are normally referred to the geriatrician or to the general physician currently responsible for admissions. Because the geriatrician controls only 20 assessment beds at hospital A he is often unable to accept such patients and the majority are taken into medical beds under the control of the general physicians. If after treatment these patients do not recover sufficiently to be discharged, the geriatrician is asked to assess them for long-term geriatric care. Patients requiring such care are to be found in general medical, geriatric, orthopaedic and surgical wards, as well as in general practitioner beds in smaller hospitals.

22. The geriatrician recognised that the admission to medical wards of elderly patients ran counter to a recommendation of the Health Advisory Service that such patients should be admitted directly to geriatric wards. But it was a fact of life that there was an acute shortage of geriatric beds in the district compared with the Department's recommended scale. The geriatrician explained that it was his practice when a vacancy arose on a long-stay ward to give first priority to patients in his assessment beds and second to people in their own homes no longer able to care for themselves. The third priority was 'relief admissions' to give relatives a break from caring for an elderly, infirm relative and fourth came patients occupying beds in other wards. However, since this case, he had agreed to add to his waiting list anyone referred from another speciality irrespective of residence, even though he knew there was no chance of a bed in most cases.

23. The physician's SHO told my officers that after the complainant's father had been in the medical ward for a fortnight they would have been thinking about discharging him to his daughter's home or to a nursing home or to a long-stay geriatric bed. The SHO knew that the relatives could not care for him or afford a nursing home, and said that there were never enough geriatric beds in the district. Therefore the only possibility was a transfer to a geriatric bed in the other county. As this prospect upset the relatives, the medical staff called in the locum geriatrician but she would not accept the complainant's father for long-term care.

24. The locum geriatrician told my officer that she first heard of the case through the SA and said she would not accept any patient without first assessing him. She was asked later by the medical team to assess the complainant's father, and on 21 November she found that she could not consider him for rehabilitation at the time because he was confused and unable to talk to her properly. She recorded that as he was not a resident of the area he was not eligible for a long-term care bed; but if he improved she would take him for rehabilitation. The geriatrician said that he had checked whether the complainant's father had a family practitioner locally since that was the primary test in determining residence. There was no local FP and the geriatrician therefore stood by his locum's decision. He said that the complainant's father was never his patient and what happened to him after the geriatric team refused to accept him was the responsibility of the medical team caring for him. There had been no discussion of the case between the physician and himself but that was not unusual as there was very little communication at consultant level; the physician's junior staff usually wrote to other departments.

25. In their reply to the complaints, officers of the AHA referred to the acute pressure on geriatric beds in the district and to pressure on acute wards in October 1978 due to the number of medical emergencies. But they said that the decision not to admit the complainant's father to a long-stay bed was based solely on the fact that he was considered to be a resident of the other county; it had nothing to do with the part of the county in which the complainant lived and patients from that area were frequently admitted for geriatric care. Although pressure on beds made the work of the medical and nursing staffs more difficult, they were secondary to the policy of long-stay admission in the area of residence. The DA confirmed to my officers that the point about the catchment area mentioned by the county councillor (paragraph 19) had no bearing on the case; the problem was that the geriatrician did not have enough beds and was therefore unwilling to admit anyone from another area.

26. In evidence to my officers the complainant added that she was most distressed by the refusal of the geriatrician to speak to her about his decision not to take her father. The county councillor thought it caused the complainant and her husband to feel that they were in the hands of an uncaring bureaucratic machine and that no one with the power to make the decision was prepared to listen to their problems or explain the situation in a helpful way. The geriatrician explained to my officers that it was his practice to speak to the family practitioner concerned rather than to the relatives of potential patients, because time simply did not permit of his doing otherwise. In this case he arranged for his social worker to see the complainant to explain the difficulties.

Findings

27. The department of geriatric medicine was, and still is, short of both beds and staff. The geriatrician decided in line with his normal practice that the complainant's father's place of residence was the determining factor. Its application in this case led to the transfer of an 81-year-old patient by the physician's team to a hospital more than 40 miles from his only relative, the complainant. The geriatrician has said that he now adds patients to his waiting list irrespective of their place of residence. I am satisfied that the fact that the complainant's address was not in the official catchment area was of no relevance. Although I understand the position has improved to some extent by the opening of more beds for the elderly at hospital A, the need for increased provision for the district geriatric service remains – a problem which I find is not restricted to this particular AHA.

28. I do not think that the place of residence was the sole factor in transferring the complainant's father to hospital B. The more important reason was the overall shortage of beds under the control of the geriatric department. Furthermore, problems so created are in no way helped by the apparent lack of co-operation between that department and the medical department – a situation well exemplified by this case.

29. Once the complainant's father was regarded as requiring a long-stay bed his case was properly referred to the geriatric department. I find that that department would accept no responsibility for him and the geriatrician refused the complainant's request to see him. Although the complainant's father was in the care of another consultant, in the circumstances of this particular case I consider that it might have been better if the geriatrician had agreed to see the complainant especially as the MSW had informed him that she had suggested to the patient's daughter that she might wish to see the geriatrician (paragraph 7). The geriatrician's normal practice of discussing a potential patient with the local family practitioner was not really applicable here.

(d) *The attempt to defer the transfer*

30. The complainant said that her father was transferred to his home county just three days before Christmas and a request to defer the transfer until the New Year was refused. The county councillor told my officers that she suggested to the DA that if the complainant's father could be kept at the hospital over Christmas the complainant and her husband would attempt to arrange local accommodation but if they failed to do so by, say, 15 January, they would agree to the transfer. But the request was turned down by the medical team. The county councillor provided evidence from a former patient of hospital A and another local hospital over Christmas that there was a number of beds empty and no shortage of staff in both hospitals.

31. The records show that the letter of 20 November from the physician's SHO to a consultant geriatrician in the other county (paragraph 8) had been incorrectly addressed and on 8 December she wrote in similar terms to the consultant geriatrician at hospital B, mentioning also the possibility of an exchange of patients. He replied on 18 December that as the father was a local man, he thought hospital B ought to take him in forthwith; although it was a

long way from his home it was the only place at which the consultant had beds available at that time. On 20 December the complainant's Member of Parliament, at the county councillor's request, wrote to the Chairman of the AHA that the complainant had apparently been assured that her father would not be discharged from hospital A until she had found alternative private accommodation for him and that in any event, she would be given ample notice of his discharge. The Member asked if the case could be reconsidered with a view to keeping him there at least over Christmas and the New Year period. The SA asked the geriatrician if he would accept the complainant's father into one of his beds against a written undertaking from the complainant that she would make arrangements for transfer before a date to be agreed in January. But the geriatrician was unwilling to do so because the father did not live within the catchment area and if he were admitted there would be one bed less for patients from that area. On 21 December the physician told the SA that he could not comment on the geriatrician's decision but the complainant's father would have to go from the medical ward. Both the SA and the DA pressed the geriatrician again to admit him but he would not do so. The SA told the complainant that in these circumstances the transfer would have to go ahead the following day. The geriatrician recalled discussions taking place with the DA and the SA just before the transfer took place; the SA told him that the complainant's father would be transferred by the physician to the other county and that there would be problems. His reply to the SA was that he would not 'have a pistol held to his head'. He was asked if he would take the father over Christmas against an undertaking by the relatives but he had grave reservations about such undertakings since he had previously taken patients for supposedly short stays only to find that their relatives would not accept them back. In any case, if the undertaking related to a short period only, there would have been no point in transferring the father from a medical to a geriatric bed.

32. The physician informed my officers that at the time he personally controlled fewer than twenty beds at hospital A, but he had others elsewhere. As far as he could recall the beds were full over Christmas, but if any were empty they were not necessarily staffed. Most of his patients, the physician said, were emergency admissions and his waiting list was very small; the average length of stay in his beds was eight days whereas the complainant's father had been there for eight weeks. The physician recalled being told that the complainant's father was not a resident of the district's geriatric catchment area and he thought it very sensible of his doctors to take the precaution of writing early to the geriatrician in the other county. The physician also recalled discussion with the SA immediately before the transfer but said he was not told of the suggestion made by the county councillor on the complainant's behalf about the limited period of stay nor specifically asked if he would keep her father over Christmas. When the bed became available at hospital B they had to take it. He himself had no communications with that hospital to see if the bed could be held open until after Christmas. Had that been possible and had he plenty of spare beds, he might have agreed to keep the complainant's father over Christmas although he thought that any request of that nature would have been another manoeuvre by the relatives to delay the transfer. The physician accepted that had no bed been available in the other county the complainant's father would have remained in a medical bed.

33. The physician's HO went on leave on 15 December. The SHO said she was not aware of the proposal to keep the complainant's father until January against an undertaking from the relatives but she would not have wanted to do so in case they lost the bed at hospital B. There was a shortage of geriatric beds everywhere and once one was offered it was important to take it up immediately or it would be lost. Although there might have been some empty beds over Christmas, they were always busy at hospital A, and it would have been awkward to have kept the complainant's father any longer.

34. The DA and the SA at separate interviews detailed their attempts to influence the medical staff to keep the complainant's father over Christmas. The DA said that he met the geriatrician on 20 December and found him unwilling to admit the father because he was not resident in the catchment area; early the following morning the DA asked the geriatrician to reconsider his decision in the light of the suggested undertaking. But he again refused on the grounds that there would be one bed less for local patients. The SA could not recall whether he told the physician about the proposal to keep the father over Christmas against an undertaking from the relatives. The SA did not suggest to the medical staff that they try to hold the bed in hospital B over Christmas because they considered the father's condition such that it was immaterial to him where he was. He recognised that the benefit would have been primarily to the complainant and her husband, but the administrators had no power to override the medical staff's decision on the allocation of beds.

35. The consultant geriatrician at hospital B who agreed to take the complainant's father told my officers that in general he did not have much difficulty in placing male patients in long-stay geriatric beds. He did not recall being told that the relatives wanted the father to stay in their home county although, in fact, I have seen that the SHO's letter to him made this clear. He said he thought he was doing the complainant's father a favour by bringing him nearer home before Christmas. The consultant at hospital B had no recollection of any request to hold the bed open until after Christmas but said that, had he been asked, he would have agreed although he would probably not have wished to hold it until mid-January. He said that he had many requests from local residents to admit relatives from other areas and did his best to accommodate them if he had beds available.

36. I have seen that the bed occupancy figures for the medical wards at hospital A show that 71 beds were nominally available and that total bed occupancy varied from 47 on Christmas Eve to 70 on 29 December; on the 24-bedded ward in which the complainant's father was nursed from 17 to 23 beds were occupied between 20 December and 15 January.

Findings

37. I think the proposal made by the county councillor for the complainant's father to be kept in hospital A until 15 January was asking rather too much. But clearly the period was a negotiable one; the Member of Parliament suggested Christmas and the New Year period only, and given that the complainant and her husband had not been informed of the proposed actual transfer until 18 December, I would have thought that a measure of goodwill would have been particularly appropriate at this time. There was always at least one bed available

over the Christmas and New Year period in the ward occupied by the complainant's father. The evidence also suggests that the bed in hospital B could have been held for him over Christmas if the consultant geriatrician there had been approached. But the physician and his team at hospital A who made the arrangements made no such approach. This is not surprising because there is no evidence that they, in turn, were made aware of the agreement of the complainant and her husband to give any undertaking. There was clearly a failure of communication between the administrators and the appropriate medical staff in this respect. The administrators concentrated on the geriatrician in their attempt to meet the county councillor's request, but at no stage was the complainant's father the geriatrician's patient. I find that the request for prolonging the stay for a limited period was mishandled.

(e) *The transfer to hospital B*

38. The complainant said to the AHA that despite his poor state of health her father was transferred to hospital B on a cold, foggy day wearing only his pyjamas and dressing gown. She told my officers that when the physician's SHO told her and her husband on 19 December that her father was fit to travel for two hours by ambulance they said it was inhuman. They asked if they could accompany him on the journey but were told by the nursing staff that they might not be able to return in the ambulance. They said that her father had no idea of where he was going and on arrival at hospital B, they learned later, he called continually for his daughter. The complainant said that the sister of the ward at hospital B to which her father was transferred (the ward sister) was very angry that he had travelled in his pyjamas and dressing gown in such bad weather. The complainant added that when she visited him on 23 December she was asked for his outdoor clothes; no one at hospital A had asked her for them and since most of them were at her own home she could only provide old clothes from his flat.

39. The physician's SHO told my officers that the complainant's father did not know what was going on and certainly had no idea that it was Christmas. She did not remember examining him on the day of his transfer but said that he would have been seen on the physician's round on 21 December. Patients were not always seen on the day of discharge but if there was any change in their condition the nursing staff informed the medical staff. In the father's case the SHO considered he was fit for transfer; in her opinion his problems were not medical but nursing and she saw no reason why he should not travel. The staff nurse told my officers that his condition on the day of transfer was unchanged. I have seen that the nursing notes record her view that he was fit to travel. She said that he would not have been affected by the weather. He was transferred by ambulance as a stretcher case for which pyjamas and dressing gown were the normal mode of dress and he would have been well wrapped up in blankets; the ambulance men always ensured that patients were warm and the ambulance was able to pull right up to the ward door at hospital A. If patients were well enough to sit they travelled by car in outdoor clothes. The staff nurse remembered being asked whether the complainant could accompany her father and giving the normal reply that relatives are welcome to go in the ambulance but it was the policy of the ambulance service not to bring them back because the ambulance might be diverted to another case on the return journey.

40. The area chief ambulance officer (the CAO) told my officer that notes for the guidance of staff ordering ambulance transport were issued well before December 1978. They showed that it was up to the hospital to decide if a nursing or other escort was necessary for a patient, but relatives were allowed to escort young children and the elderly. The CAO said that every effort was made to return relatives to their point of departure although the service reserved the right to divert the vehicle if necessary. Even if this happened, however, efforts would still be made to take a relative back. It was common practice, the CAO said, for an escort to be provided for an elderly patient travelling a long distance. In this case the records show that no clear indication was given to the ambulance service whether the complainant's father would be escorted. He travelled as a stretcher case in a vehicle which, the CAO said, was very well heated and which carried ten blankets and hot water bottles. At hospital B there was a delay of half an hour before the patient was taken to the ward (in the CAO's area it is generally the ambulancemen's responsibility to do this), but the CAO said that the ambulance doors would have remained closed and the heater kept on during this time.

41. The ward sister explained to my officers that it was a cold, foggy morning and after the two-hour journey in pyjamas and dressing gown the complainant's father was cold even though the ambulance was heated; in her view he was improperly dressed for transfer and she was very angry at that. The ward sister said that the complainant's father was frail, confused and very deaf and hardly recognised anyone over Christmas; she could not understand why it was necessary to transfer him just before Christmas and she supported the complaint. The registrar in geriatric medicine at hospital B who examined the complainant's father about half an hour after his arrival said that he was confused and unaware of his own name and address; but, in her opinion, so long as he was warm and comfortable in an ambulance he would feel all right. The clinical and nursing notes confirm that he was confused on arrival and remained so until he died. The clinical notes also show that on 29 December his condition deteriorated and he was placed on the seriously ill list that day.

Findings

42. I have been assured that the condition of the complainant's father at the time of transfer was unchanged from that when he was seen by the consultant on his normal ward round the previous day. The decision whether a patient is medically fit for discharge or transfer to another hospital is a matter for a doctor to decide in the exercise of clinical judgment and I am not empowered to question such a decision.

43. I have found that the complainant's father travelled on a stretcher in a heated ambulance when he was transferred and I consider pyjamas and a dressing gown to be an appropriate mode of dress. I make no criticism of the fact that hospital A did not suggest to the complainant that her father's clothes should have accompanied him on transfer when the nursing notes indicate that he did no more than sit in a chair for short periods at hospital A. But I have found that the staff nurse responded to the complainant's request to escort her father with quite the wrong emphasis about the ambulance service's policy in such cases. I am satisfied that the ambulance service would have done their best

to take the complainant back to her home county, even if the vehicle had been diverted en route. I uphold this aspect of the complaint and invite the AHA to remind staff who are involved in ordering transport about the policy of the ambulance service as regards the return of relatives who accompany children or elderly patients.

Conclusions

44. The different aspects of these complaints all revolve round the decision to transfer the complainant's father to hospital B on 22 December. I have given my findings in paragraphs 11, 17, 18, 27, 28, 29, 37, 42 and 43.

45. The geriatrician has made some changes in his practice since this case arose but they seem to me unlikely to eliminate the possibility of further similar cases. That, I think, depends upon improvement in the geriatric facilities in the district. In this connection I am pleased to record that 12 more beds for elderly patients became available at hospital A at the beginning of 1981 and twelve more are expected to open shortly. But the case also shows that the rapport and communication between the physician's and the geriatrician's 'firms' are not as they should be and I invited the AHA to consider how this might be improved. The AHA have agreed to this recommendation. They also inform me that they have agreed to set up a Working Party of Authority members and officers, members of the District Management Team and a representative of the local Community Health Council to examine the geriatric services in the Health District. The AHA have further agreed to remind staff of the policy of the ambulance service about the return of relatives acting as escorts. They have asked me to convey to the complainant and her husband on their behalf their sincere apologies for the shortcomings identified in this report, and this I gladly do.

Case No. W.231/79–80 – Care and treatment in hospital and discharge arrangements

Complaint and background

1. The complainant's husband, then aged 80, spent two weeks in hospital in February/March 1979 having suffered a stroke. On 6 April he was re-admitted following a fall at home. He was discharged home on Friday 27 April and died there on 2 May. The complainant said that:

(*a*) the registrar caring for her husband caused her distress and unnecessary grief before Easter by speaking to her in an off-hand and condescending manner;

(*b*) on 18 April she discovered that the drawsheet of her husband's bed was soiled with dried faeces and that his feet were similarly soiled, two days after he had been given an enema;

(*c*) on 26 April her husband was allowed to fall causing him to bruise his shoulder, hip and leg, even though on the previous day a staff nurse on the ward made light of the risk of such an occurrence once he went home;

(*d*) her husband was sent home by mini-cab instead of by ambulance as

arranged, arriving home soiled and wet: the apologies offered for this failure in service were half-hearted;

(*e*) an assessment issued by the hospital nursing staff to the community nursing service was inaccurate and statements by the staff nurse and the hospital social worker that her husband needed little general nursing were not borne out by the facts;

(*f*) no arrangements were made for domiciliary care from 27 to 30 April and those for the laundry service were never implemented; and

(*g*) the replies of the Area Health Authority (the AHA) to her complaints were unsatisfactory.

Investigation

2. During the investigation I obtained the comments of the AHA and the registrar and I examined the relevant papers, including the case notes. My officer met and discussed the complaints with members of the medical and nursing staff concerned. He also met the complainant.

(a) *The registrar's manner*

3. The complainant said that on Maundy Thursday, 12 April, the registrar dealt with her in an off-hand and condescending manner. The registrar told her she had suggested to the complainant's husband that he should go home for Easter. When the complainant said she should have been consulted first, especially as the notice was so short, the registrar replied that her husband had said she would not agree; but the complainant pointed out that this was because she worked at home. She and the registrar discussed the husband's condition and the complainant said that when her husband was in another ward some weeks previously she had been told his lungs were clear whereas she was now told they were not. The registrar said that perhaps the complainant had not previously bothered to enquire further. The complainant told my officer she was so upset, particularly at the suggestion that it was simply inconvenient for her to have her husband home for Easter, that she burst into tears. She said the ward sister and the staff nurse comforted her and told her the registrar might be a little brusque but did not mean to upset her. The complainant said she understood the hospital had staffing problems and for this reason, as well as not to upset her husband, she had not complained to anyone at the time.

4. The registrar told my officer that at the interview in question she discussed with the complainant the various conditions from which the husband was suffering and the tentative prognosis, bearing in mind that at the time the investigations were still incomplete. She was disturbed to learn that the complainant thought her attitude off-hand and condescending. This was not her habit in dealing with patients and relatives on this or any other occasion and she was extremely sorry that the complainant interpreted it as such. The registrar said she was well aware, as was the complainant's husband, that the complainant had to earn a living to support her husand and herself, and that for this reason she might not be willing to have him home for Easter. It was therefore quite possible that she would have said to the complainant that she had not expected her to agree but it would have been said as an observation, not as an accusation. The registrar said she was placed in a difficult position as

regards the disclosure to the complainant of her husband's cancer. Previous investigations had yielded information that cancer was probably present but this information was not passed to the complainant or her husband by the medical team then responsible for him. The registrar said that when treating elderly patients doctors sometimes withheld a tentative diagnosis since other conditions might intervene. However, on this occasion the complainant asked a direct question which she felt duty-bound to answer. But the registrar assured my officer she did not remark that the complainant might not have bothered to enquire further.

5. The ward sister told my officer that she spent more time with the complainant than she did with most relatives and she knew the complainant was behind with her work and under financial strain as a consequence of caring for her husband. The sister did remember reassuring the complainant when she found her in tears after speaking to the registrar but thought the problem was caused by the conflicting pressures on the complainant's time placing her in an impossible position. The knowledge that the husband wanted to come home did not help the complainant although her husband appreciated the problems.

Findings

6. I think it was unfortunate that the possibility of the husband going home over Easter was not mentioned to the complainant earlier and before the husband's views were sought; such a last-minute proposal was almost bound to heighten the tension and pressure on the complainant. Moreover, I have little doubt that disclosure of the grave prognosis, requested though it was, added to her distress. I think it was right for the registrar to have responded fully to the request, but I believe it was the information itself more than the registrar's manner which caused the complainant to be upset.

(b) *The soiled bed*

7. When she first wrote to the AHA on 27 May 1979 the complainant drew attention to the occasion on which she found her husband's bed and feet soiled with dried faeces two days after he was given an enema. The AHA replied that the complainant had not complained about the quality of the nursing care during her many conversations with the ward staff and the Nursing Officer (in fact a Senior Nursing Officer, referred to in this report as the SNO) was therefore unable to comment on the episode. The AHA's reply referred to a statement by the SNO that the complainant's husband had a history of double incontinence prior to his admission, but after treatment the nursing records included references to only one instance of urinary and one of faecal incontinence; in the same letter the AHA recorded a statement by the consultant physician in charge of the husband's care (the consultant) that the husband suffered incontinence of urine occasionally but there was no record of faecal incontinence.

8. In response the complainant said that she did complain about the soiling incident to the male staff nurse in charge of the ward at the time insisting on the drawsheet being changed and her husband's feet being washed. She repudiated the SNO's statement that her husband had a history of double incontinence saying that at no stage during the five weeks before his re-admission was he incontinent, although he had to use a bottle frequently and suffered faecal

leakage for twenty four hours after the administration of suppositories to help his bowel condition. She also disputed the hospital's records of her husband's incontinence and pointed out the contradiction in the SNO's and the consultant's statements. The AHA replied that there was no record of the incident and the nursing staff on duty on the ward on 18 April could not recall a complaint.

9. The complainant told my officer that the male staff nurse to whom she complained on 18 April apologised and remedied the situation immediately. She confirmed that her husband was not incontinent at all at home but was incontinent of urine in hospital and because the hospital staff administered enemas instead of suppositories his bowels had to be emptied manually. She was not complaining that his condition worsened in hospital but that the nursing report was inaccurate.

10. The SNO told my officer that she had identified and questioned the male nursing staff on the ward on 18 April but they had no recollection of the incident. She explained that her statement that the complainant's husband had a history of double incontinence was taken from the nursing notes for his previous stay in hospital. She agreed with the complainant that her husband's bowels did not work and that the faecal discharge from which he suffered after an enema was not due to any general condition of incontinence. The SNO said that the regular administration of enemas was the treatment ordered by the medical staff to prevent impaction of faeces. She considered that the husband's condition of impaction was bound to have caused frequent urination. The term incontinence was used, she said, to describe soiling from any cause whatever and its use in this case was in no sense derogatory.

11. I have examined the nursing notes and seen that on re-admission on 6 April the complainant's husband was stated to have suffered continual faecal diarrhoea since his discharge home five weeks previously; the clinical notes record this as 'overflow diarrhoea'. The Community Nursing notes show that he was incontinent at home on 20 March. After re-admission several instances of urinary incontinence are recorded in the nursing notes as are two of faecal incontinence. The records also show that he was given an enema on 17 April with soft result and that he had diarrhoea once during the night; he also received four hourly pressure area care during that day and night. On 18 April he underwent a lymph node biopsy.

Findings

12. The complainant is certain that her husband's bed and feet were soiled but the nursing staff do not recollect the incident. I am inclined to believe that there was some soiling but, given the nature of the nursing care on 17/18 April and the biopsy on 18 April, I think that it was of much more recent origin than the complainant alleged. I note the difference of opinion over the appropriate terminology to describe her husband's condition but I make no criticism of the sense in which the SNO used the term 'incontinence'. However, I have found no evidence in support of her statement that the complainant's husband had a history of double incontinence and references included in the AHA's correspondence were contradictory.

(c) *The husband's fall in the ward*

13. The complainant said that two days before her husband was discharged

she expressed fears to the staff nurse that he might fall at home. The staff nurse advised her to ensure that all her carpets were tacked down, a suggestion she considered irrelevant and unimportant, especially as the following day he was allowed to fall in the uncarpeted lavatory area of the ward. Although the AHA told her that he sustained no injury from the fall, the complainant said he suffered severe bruising to his shoulder, hip and leg and when she visited him he was upset and crying but unwilling to talk about the fall. She spoke to the nursing staff who said they would continue to watch him.

14. The consultant said in discussion with my officer, that he saw the complainant's husband the day after his fall and found him to be rational and lucid. He did not think the fall had aggravated his condition. The registrar told my officer that she noticed no discernible difference in his condition as the result of the fall. She added that his condition fluctuated and there was no steady deterioration. The staff nurse agreed that the complainant told her she was worried about the possibility of her husband falling at home and she therefore gave her some tips on ensuring that slippery rugs were out of the way and that moveable furniture which he might hold on to was placed against a wall. She thought she probably did suggest that the complainant checked her carpets were tacked down and said that the complainant seemed grateful for the advice.

15. The staff nurse told my officer that nurses normally walked elderly patients to the bathroom and left them, making sure they were safe. The clinical notes include an entry on 26 April that the complainant's husband had a slight fall but that no damage was sustained. The nursing notes also record that he fell, that he was seen by the registrar and that periodic neurological observations were made until the following morning.

Findings

16. There is no dispute that the complainant's husband fell in the lavatory area of the ward on 26 April. The complainant has suggested that his deterioration resulted from this fall; but the medical opinion does not support her contention. That opinion was given in the exercise of clinical judgment and I cannot question it. I believe the staff nurse intended to be helpful in the advice she gave to the complainant and I have no criticism of her action.

(d) *The failure to provide an ambulance*

17. The complainant said that the main part of her complaint concerned the failure to provide ambulance transport home for her husband, despite assurances that it had been arranged, and the half-hearted nature of the apologies given for the failure. She said that the incident was disgraceful and resulted in an old man being left in wet and dirty pyjamas waiting for a taxi. She regarded a taxi as an unsuitable form of transport since her husband's condition necessitated the assistance of three or four people to get him in and out of it.

18. The complainant told my officer that the day before her husband's discharge the registrar assured her that an ambulance had been booked to take her husband home. The following day she telephoned the staff nurse to confirm that everything was ready for her husband's return, asking her to leave it as late as possible before changing his pyjamas so that he could reach home dry. At

4 pm the complainant said, the staff nurse telephoned to say there was no ambulance available, but that they would send the complainants husband home in a taxi. The complainant told the staff nurse to wait until she arrived with a friend who would help. They arrived on the ward to find the complainants husband sitting in a chair, scared and frightened. The complainant reassured him and told the registrar, 'You haven't heard the last of this!' The complainant said the registrar apologised for the mistake and walked away. The husband who was 6ft 3 inches tall was helped into the taxi, a Ford Escort, by the staff nurse, a porter, the complainant and her friend. She said it took twenty minutes to help him into the front seat of the car even with the seat adjusted back to its fullest extent.

19. The SNO told my officer that when a doctor authorised the discharge of a patient it was for the nurse in charge of the ward to make appropriate arrangements such as the notification of relatives, provision of medicine and, if necessary, transport home. In this case the ward sister was on leave and the staff nurse was off duty on Thursday 26 April. The nurse in charge on that day assumed that transport had been arranged when the discharge arrangements were discussed earlier in the week. The staff nurse on her return on 27 April also assumed that it had been arranged. But that was not the case. The SNO said that she was notified of the problem and secured the registrar's authority for a taxi to be hired. The arrangements failed not because the system was faulty but because of human error which, the SNO said, they had admitted and for which they had apologised.

20. In discussion with my officer the staff nurse confirmed that on her return to duty on 27 April she assumed that an ambulance had been booked during her absence. The complainant telephoned the ward several times during the afternoon to enquire when her husband could be expected home and when the staff nurse checked with the transport section she realised that no booking had been made. She did not know how the omission occurred but admitted that it had and was sorry for it. The staff nurse telephoned the complainant who agreed that her husband could go home by taxi but said she would come to the hospital to take him home.

21. The staff nurse said that when the complainant arrived on the ward with a neighbour both of them started to shout at the nursing staff saying that the incident revealed a disgraceful lack of care for patients. The staff nurse said that the registrar came up to apologise to the complainant but was unable to do so effectively. The staff nurse accompanied the complainant and her husband to the taxi and said she helped the husband into the front seat. She thought the vehicle was a Ford Cortina and said the husband had slight difficulty in bending but the only real help she had to give him was to fasten the seat belt. The complainant was still shouting and she slammed the door of the car with such force that the taxi driver remonstrated with her. The staff nurse said it took no more than two minutes for the complainant's husband to get into the car. She also said she had been looking after him all afternoon and knew that he was not wet when he left the ward.

22. The registrar explained to my officer that she was informed by the nursing staff that there was no ambulance to take the husband home but the complainant agreed to his return home and was willing to accompany him in the taxi, even

though she had been told that the hospital was willing to keep him another night. When the complainant arrived the registrar was on the ward attending another patient. She left the patient and went to the complainant to apologise for the mistake. She told my officer that her apologies were sincere, the more so since she herself was upset at the fault in the hospital's arrangements and for the inconvenience caused to the complainant and her husband. However, the complainant was distressed and displeased with everyone and walked away with her husband.

23. The consultant told my officer that he examined the husband on the day of his discharge home (paragraph 14). He did not consider that the journey by car as opposed to ambulance could have affected his condition. The consultant said he was nonplussed by the complaint that the registrar's apology was half-hearted; he had known her since she was a student and had never known her to be other than courteous and pleasant.

Findings

24. I can understand the complainant's annoyance that, after obtaining confirmation from the registrar that an ambulance was booked and making several telephone calls, it turned out that the ambulance had after all been forgotten. This was a regrettable lapse which I have found was the result of human error. It was admitted by the hospital and an apology was made at the time and subsequently by letter. The staff were aware of the complainant's concern over her husband's discharge and I have no doubt they were dismayed and upset at the mistake made in the arrangements. The complainant herself was angry and threatened to take the matter further; and I doubt if any apologies at that time would have been acceptable to her. But I do not believe the apologies were half-hearted. I have no reason to doubt that the complainant's husband was wearing wet and dirty pyjamas when he arrived home but there is a direct conflict about the difficulty he had in getting in and out of the taxi. I am inclined to the view that the complainant's understandable distress about the failure to provide an ambulance caused her to exaggerate the detail. I hope that she will accept the opinion of the medical staff that the incident would not have affected the eventual outcome.

(e) *The assessment on discharge*

25. Before the complainant's husband was discharged the staff nurse issued a confidential assessment form to the Community Nursing Service (the CNS) giving details of treatment required from them and an assessment of the patient's capabilities. The form, which the complainant gave to my officer, showed the treatment required as high disposable enemas twice weekly with the first one due on 30 April 1979; bath once a week and the laundry service to be implemented. There was also a note that a voluntary sitter had been applied for. According to the assessment the husband could walk alone, could manage stairs, toilet and personal clothing with help, and he needed a special diabetic diet. The complainant disagreed with every entry in this assessment except the last one and with statements she said were made by the staff nurse and Hospital Social Worker (the HSW) that her husband needed little general nursing. She said he was totally incontinent, had lost the use of his bowels and was incapable of walking

more than a few steps. She also disputed a statement by the consultant that he noted improved mobility in her husband, pointing out that the consultant was on leave during the first two weeks of her husband's stay in the hospital and that any observation of him walking unaided would have been made before he fell. She said she did not know whether the doctors were unaware how near to death her husband was or that they did know but chose to withhold the information from her or that her husband's fall coupled with the rough journey home shortened his life expectancy considerably.

26. The consultant told my officer that on his ward rounds he regularly asked patients to leave their chairs and walk around before he completed his clinical notes on their mobility. He personally witnessed the complainant's husband walking unaided on such a round on 23 April, and although he had not seen him dress, walk up stairs or go to the toilet, he saw no reason why he could not have done all these things with help. He had therefore no reason to doubt the veracity of the assessment given to the CNS. The consultant recalled that his decision to discharge the husband on 27 April was taken after consultation with the nursing staff and the HSW at the preceding Monday's ward round. He met the complainant on 26 April and explained to her in a lengthy interview the gravity of her husband's condition, telling her that the lung carcinoma from which he was suffering would be fatal and he would not survive the nine months one would normally expect for such a patient. But he did not anticipate at that time that the husband would die the following week. He thought that his rapid deterioration and death was due to cerebro-vascular disease rather than cancer; in cases like this with such an unpredictable condition it was impossible to know when further strokes might occur. The consultant pointed out to my officer that the complainant had been given the facts about her husband's condition and details of the sort of help available to her at home and she was given the choice whether her husband should be transferred to a terminal hospital or discharged home. The consultant said he made it clear to the complainant that if her husband's condition deteriorated he would immediately be accepted back into hospital. The consultant added that he examined him again on the day of discharge; he said he felt fit enough to go home and wanted to do so and the consultant saw no reason not to discharge him.

27. The registrar told my officer that the complainant's husband could walk unaided and she recalled seeing him do so. She said that his condition was unpredictable but she told the complainant that she thought it would be possible for her husband to stay at home given some support and help although she explained they could help in arranging terminal care at a hospital if this was desired. She also confirmed they would re-admit him instantly if asked to do so. On the question of his life expectancy the registrar explained that the complainant pressed the consultant and herself into giving a firm prognosis. But they were reluctant to be definite and gave a very guarded reply. She said that as well as having cerebro-vascular disease the husband had had two or three strokes and was at great risk of another and he also suffered from the most rapidly progressive cancer there was. His condition fluctuated very much.

28. The ward sister was on leave during the last week of the complainant's husband's stay in hospital but she told my officer that before she left the ward she noted his increased mobility. The staff nurse said that she completed the

assessment form and she believed it to be correct; if there was any room for doubt at all it was with regard to the husband's ability to walk unaided. She had indeed seen him walk unaided, but he did have a walking stick and, normally, would probably have used it. She did not see him on admission but she recalled having seen nurses walking him around the ward and encouraging him to move around. On his last few days in hospital the nurses took great pains to encourage him to go to the lavatory rather than to use a commode. The HSW said that before she met the complainant on 25 April she had been told by the ward staff that full nursing services were not required. She, herself, was not able to comment on the level of general nursing care that was necessary, because this was not in her province.

29. I have exmained the nursing notes and seen various references to the mobilisation of the complainant's husband. On 10 April he was said to be mobilising well; on 22 April the entry reads, 'slow day; up and about with difficulty'; and for that night, 'out to toilet during night, a little awkward at times'; on 25 April, 'mobilising well'; on the following night, after he had fallen in the lavatory area during the day, he was said to have passed a'usual night' though to be very unsteady on his feet. The clinical notes for 12 April describe his weakness as having improved and his mobility as 'good' and on 18 April the record says he was 'mobilising well'. On 23 April he was said to be walking very slowly but to be confident of managing at home and on 25 April to be 'mobilising'.

30. My officer also spoke to members of the CNS who attended the husband at home following his discharge and to a nurse (the night nurse) who attended him on the night of 30 April. The Community charge nurse (the charge nurse) who made his own assessment of the husband on 30 April was quite sure he could move around with help and walk to the commode in his bedroom; he thought twice-daily visits by nurses would be necessary together with a night sitter once or twice a week. The night nurse told my officer that there were no particular nursing problems when she nursed the complainant's husband.

Findings

31. The assessment form completed by the staff nurse represented her professional judgment of the husband's capabilities and I do not question such judgment. I do not dispute that the consultant saw the husband walk unaided on 23 April but there is evidence that at times he had difficulty in mobilising and that he would probably have used a walking-stick to assist him. As for the husband's life expectancy the consultant has explained the difficult position in which he found himself. I am satisfied that he was frank with the complainant and gave her the best indication he could without giving grounds for optimism or immediate concern. He confirmed to my officer that he was surprised that the husband had died so soon.

(f) *Home care arrangements*

32. The complainant said that when her husband was discharged home no arrangements were made for domiciliary care during his first four days at home and the incontinence laundry service was never implemented; she was told that the district nurse would not call before Tuesday 1 May. She said that from the

time her husband arrived home until his death it was necessary to change his bedclothes and bed linen every two hours. She had no washing machine and the situation after twenty-four hours was chaotic. On Sunday 29 April less than 48 hours after discharge her husband's condition was so bad that she called her family practitioner (the FP) who told her her husband was dying and arranged for nursing care both day and night to start on the morning of 30 April. The complainant said she had no sleep at all until the evening of 30 April when a night nurse came to sit with her husband. The complainant said that before her husband was discharged she herself arranged for a home help to call and asked the HSW on 25 April to arrange for community nurses to call and for the incontinence laundry service to be arranged. She said that she was offered no other help by the HSW and denied the HSW's claim that the meals-on-wheels service and a voluntary sitter were offered. She particularly objected to the suggestion that a voluntary sitter would enable her to go out and pointed out she had to work at home to support her husband and herself. She added that the HSW had said to her that she must think the social services had let her down.

33. The consultant told my officer it was for the hospital nursing staff and the HSW to arrange home support for discharged patients. However, it was easier to activate the support services at the beginning rather than at the end of a week and if he had suspected any deterioration in the husband's condition he would have discharged him on the following Monday instead of Friday 27 April, if his condition had allowed. But he added that the community nurses could be called out by telephone if necessary during the weekend. The SNO accpeted that the nurse in charge of the ward was responsible for making discharge arrangements appropriate for the patient's condition including liaison with the social workers and liaison with the CNS.

34. The staff nurse remembered discussing with the HSW that the complainant's husband would require the incontinence laundry service and although she had not made such arrangements before and could not now remember doing so in this case, she assumed that she had telephone the clinic where the service was based and had asked for a laundry service for the husband. She also remembered asking the office staff to arrange for a community nurse known to the complainant to visit on the evening of discharge. She completed and despatched the assessment form giving details of the treatment required; and I have noted that this indicated the date of first treatment as 30 April. The staff nurse could not remember how she arrived at that date. I have seen that the assessment form also records that the diagnosis of the husband's condition was given to the CNS over the telephone.

35. The HSW told my officer that she offered the complainant a home help and the meals-on-wheels service, but the complainant had herself arranged the former and did not want the latter. The HSW said she offered to arrange for community nurses to call and for the introduction of the incontinence laundry service, both of which the complainant did require. She also offered to find a voluntary sitter to look after the husband and allow the complainant to go out, but this was rejected by the complainant who was reluctant to admit persons unknown to her into her home. She denied saying that the complainant must feel that they had let her down and said she did not think that was the case. She found it difficult to explain anything to the complainant who was under considerable pressure and tension.

36. The Senior Nursing Officer in charge of the CNS (the Community SNO) confirmed to my officer that when a patient requiring nursing care was to be discharged home it was the normal practice for a nurse on the ward to send an assessment form to the CNS clinic and to telephone clerical staff at the clinic to give them details of the discharge, which would be passed on to a community nurse. The Community SNO said that in view of the diagnosis given on the complainant's husband she would have expected the first visit to the complainant's household to have been paid the day after discharge, irrespective of the fact that the first enema was not due until 30 April. She explained that the CNS always liked to assess the situation of patients they were to be responsible for, since patients often behaved differently when at home. During such a visit the nurse would have assessed what was required of the incontinence laundry service. A Community NO explained that although the laundry service would have been alerted by the ward staff no action would have been taken until a Community nurse or health visitor confirmed the requirements to a nursing officer or sister in the CNS responsible for authorising the provision of the service. The service provided could vary from the supply of incontinence pads and appliances to the provision of a full drawsheet service. The Community SNO said that unfortunately, the card recording the request for the laundry service in this case had been misplaced.

37. I have examined various records kept by the CNS. I have seen the record of a telephone call from the staff nurse at the hospital which records a message at 13.10 hrs on 27 April reading 'Twice a week visits for high disposable enema and weekly bath. Laundry service requested. Discharge today 27/4/79. Next enema Monday 30/4/79. Wife knows about condition. Patient does not.' The message form shows that the message was passed to a community nurse at 15.45. I have also seen a message from the FP received at 12.05 on 30 April recording his visit to the husband the previous day and requesting daily care. This message was passed on to a community nurse at 15.00 hrs the same day. The folder of nursing notes which was kept at the complainant's home contains a record of a visit, incorrectly dated 19 April by the charge nurse who stated that the complainant seemed to need help in coping with her husband's personal hygiene; that an enema and suppositories were given with little result and that the bowels were evacuated manually. The note continues 'For twice daily visits GNC (general nursing care) and night nurse to help to bed in the evening. Night sitter is to be arranged once or twice weekly in order to give his wife a rest. Inco laundry service arranged.' Two more visits are recorded in the notes as having been made that day. I have also examined the card recording visits to the complainant's husband which is kept at the headquarters of the CNS; it records two visits per day for general nursing care on 28, 29 and 30 April, and for nursing care and injection on 1 May; it also records nursing care visits on 7–10 April – the first four days after the husband had been re-admitted to hospital.

38. The charge nurse could not remember when he made his first call but later produced his official diary and I have seen the entry for 30 April reading, '1 pm N/P (ie new patient) . . . [the husband] . . . —— Road'. The charge nurse said the purpose of his visit, which the complainant confirmed was the first paid by the CNS, was to assess the level of nursing attention required. A Community nurse who visited the husband on 1 May told my officer that he was not aware of any problem over laundry. He found the husband sitting on an incontinence

pad on clean sheets and said that although the complainant told him about her husband's discharge home by taxi she did not mention the laundry service. He left a further supply of incontinence pads. The night nurse who attended the husband on the night of 30 April/1 May told my officer that when she arrived at the complainant's house at about 10 pm the husband was in no immediate need of nursing care. She spoke to the complainant for an hour or so about the difficulties of nursing a relative while earning a living and said she gained the impression that the complainant did not agree with the decision to discharge her husband. She said her husband was in a clean bed, possibly on an incontinence pad, and she recalled no difficulty with bed linen nor did the complainant mention this to her. She described her visit as being wholly undramatic.

39. The consultant told my officer that the hospital authorities had given much thought to the plight of relatives who accepted terminally ill patients home and had subsequently formed a special team, which included retired hospital staff, and whose purpose was to maintain close liaison between patients, relatives and the caring authorities. The service was not started directly as a result of this complaint although the consultant said he believed it would have been of benefit to the complainant and her husband had it then been in existence.

Findings

40. I am sure that the complainant found herself under great stress and difficulty in caring for her husband but I am not convinced from the evidence I have seen that the home situation was as chaotic as she described. I am satisfied that the requests from the ward for home nursing and laundry service were conveyed to the CNS in the telephone message from the staff nurse at 13.10 hrs on 27 April. And since it is the practice of the CNS to make their own assessment of a patient's requirements I do not think that the starting date of 30 April for the first treatment which was shown on the assessment form influenced the timing of the first visit. The staff nurse is sure she asked for a nurse to call on the complainant's husband on the day of his discharge but no such request is recorded in the assessment or message forms and in the absence of corroborative evidence I cannot confirm that she did so. Nevertheless the Community SNO has stated that she would have expected the first call to be made on the day following the husband's discharge. I criticise the CNS severely for failing to make that visit. I also criticise the CNS for the inaccuracies in their recording of visits to the husband.

(g) *The AHA's reply to the complainant*

41. The complainant first expressed her discontent to the AHA in a letter dated 7 May, to which a reply was sent by the Authority on 12 June. She was most dissatisfied with the reply and sent a second letter of complaint on 27 June, but at the time of her complaint to me she had received no reply to it. The complainant thought it significant that a few days after my officer asked her on 1 October whether she had then received a reply from the AHA she should have received one dated 27 September but postmarked 3 October. However, my first approach to the AHA enclosing a summary of the complaint had not by then been made.

Findings

42. The complainant suspected that the AHA's reply of 27 September was

sent only after they became aware that I intended to investigate her complaint. That was not so. I have covered the points of the complainant's dissatisfaction in the body of this report and make no further comment on them here.

Conclusion

43. I have much sympathy with the complainant in her anxiety and distress over her husband's illness and death. The complainant had promised her husband that he would die in his home surroundings and she was clearly ever mindful of that promise. I can also understand that the demands of her employment at home as a journalist and of maintaining an income conflicted with the heavy responsibility of caring for her sick and dying husband and placed an almost intolerable burden on her. I have recorded my findings on the individual points of complaint earlier in this report, upholding in part some serious failures in the service to the complainant and her husband. The AHA have already apologised for some of these. But the AHA have asked me to convey on their behalf their sincere apologies to the complainant for the distress and inconvenience caused as well as the failure to provide a service and this I gladly do. They admit that there was an error in professional judgment by the community nurses in that they failed to carry out what should have been a routine visit for the assessment of the husband's nursing needs on discharge from hospital. They tell me that they have also drawn these matters to the attention of the nurses concerned and all other staff so that a lesson may be learned from them. I am pleased to note the formation of a special team to liaise with families placed in similar circumstances to those in which the complainant found herself and regard this as a positive step by the AHA in trying to lighten the load of caring relatives.

Case No. W.303/79–80 – Non-admission of elderly patient

Background and complaint

1. On 6 December 1978 the complainant's mother, aged 85, was admitted to a nursing home (the first nursing home) as a private patient suffering from shingles and post-herpetic neuralgia. She took her own discharge but was admitted later in the month as a NHS patient to a hospital (the first hospital). After discharge home on 10 January her condition deteriorated and her name was placed on the waiting list for another hospital (the second hospital). When the complainant found that there was no prospect of early admission for her mother she arranged for her to be looked after successively at two other private nursing homes. She died at the second of these on 4 May 1979.

2. The complainant said that in refusing to admit her mother to the second hospital, the Area Health Authority (the AHA) failed to provide a service which it was their duty to provide. The complainant was also dissatisfied with the response of the AHA to her request for the reimbursement of nursing home fees and private nursing charges which she was obliged to pay.

Jurisdiction

3. Under the provisions of the National Health Service Act 1977 I may not investigate the actions of family practitioners taken in connection with the services they provide under contract with Family Practitioner Committees. I

refer in this report to their actions solely in order to provide a context for the sequence of events.

Investigation

4. During the investigation I obtained the written comments of the AHA and examined the relevant documents. One of my officers interviewed members of the administrative staff of the Health District and the Consultant Physician in Geriatric Medicine at the second hospital (the consultant). He also met the complainant and the two family practitioners in whose care her mother was from time to time during the last six months of her life.

(a) *The failure to admit to hospital*

5. In discussion with my officer and in correspondence, the complainant said that when her mother was admitted to the first nursing home she was suffering from shingles. But she was unhappy there and returned home on 17 December. After a short period receiving full-time nursing under private arrangements, her family practitioner arranged for her to be admitted to the geriatric rehabilitation ward at the first hospital under the care of the consultant who had responsibility for this ward as well as for beds at the second hospital. She made a good recovery, was discharged on 10 January 1979 and again returned home to her flat where she had easy access to the warden in charge. A short time later the complainant's brother was told by the warden that his mother's health was failing and that her absentmindedness was causing difficulties. A Community Nurse visited regularly and Home Help service was provided, but her condition worsened and her family practitioner considered that she was no longer able to take care of herself. The complainant discussed with him the possibility of her mother being admitted to the second hospital (the hospital) for long-term care. She said she did not like the idea since the hospital was in her view an old and unattractive institution. But there appeared to be little alternative because the first hospital, as an acute hospital, was not for long-stay geriatric patients. She said that the FP suggested a nursing home (the second nursing home) as an alternative and the complainant's mother was admitted there as a private patient on 6 March. The complainant assumed that the FP made arrangements for her mother's name to be added to the waiting list for the hospital at that time.

6. The complainant said that at the second nursing home it was soon realised that her mother would need considerable nursing care; she tended to wander about at night and was incontinent. This led to a night nurse being assigned to look after her. Worried by the additional expense of the night nurse, the complainant telephoned the Health District on 22 March and discussed her mother's care with the Associate District Administrator (the ADA). It was explained to her that the District did not provide 24-hours domiciliary nursing care and the possibility of obtaining a bed in a hospital outside the district was considered. The ADA telephoned the complainant later the same day to say that he had been unable to find a suitable bed elsewhere within the District. The complainant said she also spoke to the consultant at the hospital. He informed her that there was a ten to twelve weeks' waiting list, although, after discussion, he agreed to put her half way up the list thus reducing the wait to six weeks. The

complainant thought this was too long a time to have to wait and she said the consultant suggested that she might try other local nursing homes.

7. On 23 March the complainant's mother transferred to a further nursing home (the third nursing home) again as a private patient. The complainant said that this was situated outside the family practitioner's area and her mother's name was transferred to a second family practitioner's list. The complainant told my officer that she did not know but assumed that the first FP notified the hospital of her mother's change of address and that she would no longer be his patient. Her mother remained at the third nursing home until she died on 4 May and during that time there was no word from the hospital of any bed vacancy.

8. The first FP told my officer that he could not recall when he asked for the mother's name to be placed on the hospital waiting list. The hospital admissions procedure was very informal; he usually telephoned the consultant and requested that a patient's name be put on the waiting list; he said it was common practice for him to follow up later with a telephone call to see whether admission was any nearer but he could not remember whether or not he did so in this case. When a bed became available the consultant's secretary would telephone his surgery.

9. The consultant said that the first FP telephoned him on 13 March telling him that the complainant's mother was generally unwell, and asked whether he had a bed for her at the hospital. He told the FP there were no vacant beds but he would add her name to the waiting list and this was done immediately. The consultant's secretary also recalled this conversation. She said that once the complainant's mother's name was placed on the waiting list she would be eligible for admission to any of the four long-stay geriatric wards in the hospital. But she was not regarded as an emergency admission either medically or socially.

10. The ADA told my officer that the complainant telephoned him on 22 March after trying unsuccessfully to speak to the consultant. He himself spoke to the consultant who was unable to specify when the complainant's mother would be admitted. The ADA discussed the complainant's concern about the problem of nursing care for her mother with the District Community Physician (the DCP) and the District Nursing Officer (the DNO). The DCP attempted to get in touch with the first FP but he was not available. The DCP and the DNO then advised him, the ADA, that if the complainant's mother required 24-hour nursing (which the Community Nursing Service could not provide) she was likely to need institutional care. The ADA telephoned the complainant and explained this adding that the District could not pay the expenses of private nursing care for her mother. The complainant enquired about nursing homes in the area and he provided her with some five addresses.

11. The consultant recalled that the ADA telephoned him and told him that the complainant was asking about the expense of night nursing facilities for her mother; the ADA also enquired how things stood about the mother's admission to hospital. The consultant told him that it would be a matter of two to three weeks before admission. The consultant said that the complainant also telephoned him the same day and spoke about the financial burden of the second nursing home; she asked for a list of nursing homes. In the consultant's view she was aware that although her mother's name was on the waiting list she

could not be admitted immediately as she was not an acute medical emergency. He strongly denied that he had told the complainant that there was a ten to twelve week waiting list – geriatric patients had not had to wait longer than six weeks for admission during the past eight years. He also denied that he had placed her name half way up the waiting list since it was not his policy to short circuit the waiting list for any patient. The consultant said that the complainant has been told that there would be a waiting time of approximately six weeks for her mother's admission to the hospital. The consultant's secretary confirmed that in the course of a telephone conversation on 22 March the first FP had asked whether the complainant's mother could be admitted quickly, but it had been explained that this was not immediately possible as the demand for admissions was then above average.

12. The first FP told my officer that the complainant had written to him to say that it had become necessary to move her mother to the third nursing home. The FP said this came as a surprise to him as he was not aware that any move was being considered. He wrote to the third nursing home giving details of the mother's medical history and added that she was on the hospital's waiting list. His letter further explained that she would need a new family practitioner as the home was outside his area. The first FP could not remember whether he also let the hospital know of the situation, although it would have been his normal practice to do so.

13. The second FP told my officer that soon after the complainant's mother's arrival at the third nursing home, the matron asked him if he would accept her as a patient. The second FP said that he would not have visited her immediately; his usual practice was to see a new patient within a week or so to check up on how she was and to find out what treatment she was receiving. He was aware that she was on the waiting list for the hospital. He did not contact the hospital about her because he knew that there was a waiting period of between one and two years before a geriatric patient could be admitted to hospital for long-term care. He added that if by chance a bed had become available he would have expected the hospital to have got in touch with him and he thought there was also some onus on the complainant to keep track of the situation.

14. The consultant told my officer that after the telephone conversation on 22 March there was no further news at the hospital about the complainant's mother until 17 April. On that day, the first FP telephoned to discuss the admission of another patient. The consultant's secretary took the opportunity to enquire about the complainant's mother and was told that she was out of the first FP's care and he could not say how she was. The secretary discussed this with the consultant and he concluded that since they had been given no further details, her name should be taken off the waiting list.

15. The consultant confirmed to my officer that when a bed became available, his secretary would telephone the practitioner of the person to be admitted. But he said that he expected the family practitioner or relative concerned to take some initiative and contact the hospital to find out what the admission prospects were. He told my officer that he believed that the complainant realised that it was up to herself or her mother's family practitioner to keep in touch with the hospital about the prospects of getting a bed. He added that the pressure on beds in the hospital was less than in many others. On average there were not

more than six people on the waiting list, a position which he thought was enviable for a District with no less than the national average of elderly people in its catchment area. The hospital were not notified of the complainant's mother's move to the third nursing home and it was only when the complainant complained following the death of her mother that they became aware of the transfer.

16. The ADA felt sure that family practitioners were generally aware how long it took for a patient to get a geriatric bed in the District and would know how the waiting list system operated. If a family practitioner wanted to check on the state of a list he had only to ask the hospital concerned but the District did not produce information in the normal course on waiting list levels. Waiting lists were, in most instances, held by the medical records office and acted on by each consultant. Where there were only a small number of people on the list, the consultant looked after it and his secretary became, in such circumstances, nominally part of the medical records office staff. The Medical Records Officer confirmed that the list to which the complainant's mother's name had been added was controlled by the consultant and he acknowledged that the procedures associated with that list might not accord with established practice in the medical records office.

(*b*) *The AHA's response to the complaint*

17. The complainant wrote to the Regional Medical Officer on 3 July setting out the details of her mother's illness and her stay in the three nursing homes. She sought repayment of the net costs incurred at the three nursing homes and for 24-hour nursing care between 17 and 21 December, which amounted to £1,186. The District Administrator (the DA) was asked to reply and he obtained the comments of the consultant and the Regional Legal Adviser. The latter advised that as no undertaking was given that the AHA could meet the cost of nursing home fees, no liability could be accepted. The DA replied to the complainant on 8 August that there was a shortage of places for elderly patients and that they have to be placed on a waiting list. He explained why the AHA could not accept liability for the private nursing home fees.

Findings

18. The complainant told my officer that the first FP had tried to get her mother into hospital in the first week of December but the FP said, in evidence, that there was no suggestion that she should be admitted to a hospital bed at that time. The complainant's mother discharged herself from the first nursing home and on 20 December the first FP had got in touch with the consultant asking him to admit her to the geriatric assessment unit at the first hospital. Prompt action was taken and she was admitted there two days later. In these circumstances I see no grounds on which the complainant could expect reimbursement of expenses incurred in December. Similarly I do not consider that the AHA failed to provide a service during that month.

19. In March the first FP approached the consultant for a bed in the second hospital but the complainant's mother was not regarded as an acute medical emergency. Accordingly her name was added to the waiting list. Those decisions were taken solely in the exercise of clinical judgment which I cannot question.

Later in March the complainant spoke to the consultant and they both say that she was told she would have to wait six weeks for a bed for her mother. With that knowledge she made arrangements for her mother to be transferred to the third nursing home. After the transfer, although the complainant and the two FPs all knew that her mother was on the hospital waiting list, I have found no evidence that the hospital were informed of her whereabouts or that any further enquiries were made about a likely date for admission.

20. In the period 23 March to 17 April beds did become available in the hospital but they were allocated to other patients. In that period the mother's name remained on the waiting list and there is no evidence that a bed became available for her. It follows that I do not uphold the complaint that the AHA failed to provide a service in March or in the first half of April. It seems possible that her name was due for consideration for a hospital bed about the middle of April since the consultant's secretary took the initiative in the telephone conversation with the first FP to enquire about her (paragraph 14). I think it would have been better if the consultant had then made further enquiries about the complainant's mother before taking her name off his waiting list but he should have been told of her move at the time it took place. However it would be no more than conjecture to say that she might have remained in the third nursing home for up to two and a half weeks longer than she would have done, had the consultant known of her whereabouts.

Conclusions

21. Although I sympathise with the complainant I do not uphold her complaints. It was the opinion of the first FP and the consultant that the complainant's mother was not an acute medical emergency in March and it followed that admission to hospital could only be by way of the waiting list. The complainant was told on 22 March that her mother would have to wait six weeks for a bed in the hospital and sadly her death occurred after that very interval. I have found no evidence of a failure to provide a service and no grounds which I consider would entitled me to invite the AHA to make any contribution towards the substantial expenses the complainant incurred in getting her mother nursed in private nursing homes.

Case No. W.307/79 – 80 – Inadequate discharge arrangements for elderly patient living alone

Complaint and background

1. On 18 February 1979 the complainant's mother, aged 81, collapsed at home and was admitted to hospital (the hospital). Although arrangements were made to discharge her, her condition deteriorated and she died in the hospital on 26 March.

2. The complainant said that:

(*a*) the arrangements for the discharge of his mother were made without adequate enquiries having been made about her social circumstances at home, and in particular the fact that she lived alone;

(*b*) the consultant physician (the consultant) applied undue pressure on her

relatives to take her home and caused distress to her by telling her that the hospital wished to discharge her but her son would not allow it;

(*c*) on one occasion, about 17 March, the consultant's house officer (the HO) referred to the complainant's mother as a 'stinking woman' and that this expression caused her mental anguish; and that

(*d*) the replies by the Area Health Authority (the AHA) to his letters of complaint were unsatisfactory.

Jurisdiction

3. The original complaint to the AHA in April 1979 contained 16 headings and as the complainant was dissatisfied with some of the answers of the AHA they suggested that the matter might be referred to me. The complainant therefore asked the AHA to do this on his behalf which they did. Before I agreed to undertake an investigation into his complaint it was explained to him that only the matters set out in paragraph 2 were within my jurisdiction. He gave me an assurance that neither he nor his brother proposed to pursue an action at law arising from the events about which he was complaining.

Investigation

4. During the investigation I obtained the written comments of the AHA and examined relevant documents. Two of my officers met the medical, nursing and administrative staff concerned. They also met the complainant and his wife and his brother. The actions of social workers are not within my jurisdiction but my officers interviewed the social work staff at the hospital to obtain background information. The complainant's account, given in paragraphs 5, 6, 7, 21 and 28 below, of the events has been compiled from his letters and the interview with my officers.

(a) *The complaint about the arrangements for discharge*

5. The complainant said that in August 1978 his mother had collapsed at her home following a stroke and after she had spent five weeks in the hospital she was discharged home. Her condition deteriorated and relatives had to visit her three and four times daily. She slept in her day clothes as she was unable to lift her arms to undress; she had to be washed and have her hair combed as she could not do those things herself; she was unable to walk to the toilet and consequently required regular 'cleaning up'; her memory of recent events was poor; she was unable to operate her radio or television or to prepare simple meals and as her vision was poor it became increasingly dangerous for her to use her cooker or a kettle. The complainant's brother said that although his mother's home had a warden service this provided only emergency cover given when the tenant pressed a bell in her flat which alerted the warden. The complainant's mother had collapsed on two occasions and the warden had not come because the complainant's mother had been unable to use the bell alarm. On 18 February she was found on the floor of her bungalow apparently in a fit, and was readmitted to the hospital. The complainant told me that the lack of social service back-up during the period after his mother's first discharge from the hospital had a great bearing on his decision to reject the discharge in March.

6. After two weeks in the hospital she had improved quite noticeably and her fits had apparently been controlled. The complainant said that on 9 March he

was informed that the consultant was 'adamant' that she was able to look after herself and that he was going to discharge her on 14 March. The complainant said that this decision had been taken without any discussion with or enquiries of the relatives as to her living conditions at home. On 10 March the complainant and his brother met the HO and 'totally rejected' the consultant's assessment that their mother could look after herself; they told the HO that the only condition under which her discharge would be acceptable to them would be if 'a signed guaranteed back-up of social and medical services was made available', but they said that the HO refused to give this guarantee. They pointed out that only sheltered accommodation 'could cope with this situation' and that no efforts appeared to have been made to obtain it. They told the HO that she required constant attention and prior to her admission the amount of time spent by the relatives visiting during the day had been 'stretching the limits of generosity of the employers of the relatives and a considerable amount of holiday entitlement had been used'. The complainant said that the HO admitted that he was not aware of her poor vision, and that he also told the HO that she was a registered disabled blind person. He said that the relatives had not even had the chance to speak to a social worker about the likely effects of his mother's discharge.

7. The complainant said that he understood that on 12 March his mother was taken to a kitchen and some assessment tests were made. He told my officers that he thought it significant that the only tests that he knew of were carried out two days after the interview with the HO and, he believed, after the decision to discharge his mother had already been made. On 16 March the HO telephoned the complainants brother to request that further assessment tests be made at the mother's home and the complainant's brother asked the HO to contact his brother but no further approach was made. The complainant said he was unable to understand why if such tests were necessary they were not done. He said that no sensible assessment of his mother's capability could have been made other than in her home. He had told the doctors that they should make arrangements for him to be there when the tests were carried out at his mother's home, as his previous experience was that the right decision had not been made and he wanted to be there to see that the tests were carried out properly. He had therefore taken possession of his mother's key and had said that in view of a previous experience he would take legal action if the warden's key was used to get into his mother's flat to carry out the tests when he was not there.

8. In their letter to the complainant dated 18 June 1979 the AHA pointed out that there was often pressure on medical staff to admit more patients than the number of available beds. 'In these circumstances, it is inevitable that doctors want to discharge patients to their homes, relatives or sheltered accommodation as soon as patients' immediate medical problems have been treated.' The AHA said that the complainant's mother was markedly improved and wanted to go home. The doctors had said that nursing and social reports indicated that she was coping well and, therefore, the total assessment of the situation was that she could go home. The letter also gave details of the assessments that were made. In a further letter on 17 September the AHA confirmed that, 'The decision that your mother was to go home was . . . taken by qualified, professional staff after careful assessment and consideration of all the factors involved, not least of which was your mother's own wish to go home.'

9. In a letter to the AHA about the complaint the consultant said that the complainant's mother had been admitted to the hospital on 18 February 1979 because she had had a grand mal fit. She made a very prompt recovery from this and was soon fully conscious, lucid and orientated. She expressed a wish to be allowed to go home, and underwent a social assessment. The senior occupational therapist (the OT) and the consultant geriatric physician (the geriatrician) had given favourable reports but the family 'remained intransigent to providing any domestic support whatever'.

10. The consultant described to my officers the discharge procedure he follows. If following satisfactory medical assessment of a patient the ward sister and the OT think discharge is appropriate, and the kitchen and home assessments have been done, then the patient could be discharged. Ideally, all four of these conditions should be satisfied, but although the home assessment was valuable it was not, in his opinion, essential. In this case he would also have preferred the relatives to have consented completely to the discharge home, but he still thought that with the help from the social services the complainant's mother could cope.

11. The geriatrician told my officers that he had seen the complainant's mother in October 1978 as well as in March 1979. She had seemed to him to be no different from a large number of hospital patients in that she would be better off at home being looked after by the social services. He said that he would make a recommendation to discharge a patient, but the decision was always in the hands of the consultant in charge of his medical care. However he would not hesitate to intervene if he felt that a patient was so ill that she should not be sent home. This was not so in this case.

12. The geriatrician's note in the clinical records dated 16 March 1979 says: 'I am afraid she is primarily a social problem. She is fully mobile, reasonably orientated, dresses and feeds herself and is continent. I would suggest requesting the social services to either arrange her discharge home (lives in a nice bungalow in ——) with day care support and meals on wheels. Failing that she would be most suitable for [Social Services accommodation] and social services should arrange it. P.S. I have personally spoken to the social worker.' There is a corresponding note made by the senior social worker in the social work records recording the geriatrician's advice.

13. The report written by the OT on 11 March 1979 to which the consultant refers (paragraph 9) reads: '[The complainant's mother] came to the kitchen today and surprisingly proved to be very capable. She performed all the tasks without difficulty being safe, mobile and co-ordinated although slow. She has meals on wheels and home help and I would suggest these be continued. She should have no difficulties in her home environment.'

14. The HO told my officer that the medical staff were of the opinion that the complainant's mother was well enough to go home. The relatives did not agree and wanted written assurance regarding support services, and the continual availability of a hospital bed. The HO said that no doctor could give such an assurance. Hospital kitchen assessments and occupational therapy were carried out essentially to see if the complainant's mother's discharge was a feasible option. They decided it was, but that a kitchen assessment at her home was needed. The HO felt that although she was ready for discharge home they

could not discharge her until he had talked to the relatives considerably more. He said that her eyesight would have been taken into account when the assessment was made. He told my officer that the disagreements with the relatives over discharge began to get more and more serious but her condition deteriorated surprisingly rapidly and she was no longer considered medically suitable for discharge and he told the relatives so.

15. The ward sister (the sister) told my officers that the complainant's mother had specifically asked both doctors and nurses if she could go home. She had been able to walk up and down the ward by herself and her vision was such that she was able to recognise someone standing near her bed before they spoke. She could also feed herself and, with some assistance, dress herself. The sister said that the normal hospital arrangements in preparation for discharge had been made. In the sister's opinion there was no reason for her to be in hospital although the decision to discharge her was one for the doctors to make.

16. Two of the ward nurses (the first SEN and the second SEN) told my officers that they remembered the complainant's mother clearly. The first SEN said that the complainant's mother was a very independent lady, who was always saying that she wanted to go home. The first SEN was aware that the relatives did not think that their mother was capable of looking after herself but from her own experience and from her knowledge of the complainant's mother she was sure that with the correct social service support the complainant's mother was suitable for discharge. She said that the mother's eyesight enabled her to get about the ward and to the toilet. She would go down to the ward day room without using a stick or tripod and often sat there. The first SEN also recalled a telephone call from the complainant telling her that he was extremely angry and did not want his mother to be discharged. The second SEN also told my officers that the complainant's mother was a somewhat independent lady whom she had nursed both times she had been in hospital. She needed some help with dressing and moving about but would try to do it herself. She did not like nurses to bath her and they had on occasions to encourage her to look after herself. She had thought that the procedures and routines the complainant's mother had gone through had been fairly standard and that she had been in generally good condition.

17. The social worker told my officers that she could not now remember the complainant's mother at all, essentially because there was nothing untoward in her care and she had been a fairly ordinary patient. There were plenty of support services arranged, and the case was not a worrying one. The social worker, her senior and her principal told my officers that because of the complaint they had reviewed the papers about her care and each of them was satisfied that normal practice had been followed, proper enquiries made and that at the time of the proposed discharge they had no reservations that with the amount of social services help that had been arranged she would have been able to look after herself at home. The senior social worker said that she had thought it important that the relatives should be seen by the doctors and she had told the HO so.

18. I have seen the social work case notes which contain numerous references to the doubts expressed by relatives about the complainant's mother's suitability for discharge and indicate that the social workers were in regular contact with the doctors and nurses responsible for her care.

19. My officers, accompanied by the principal social worker, visited the area where the complainant's mother had been resident. They were not able to enter her particular bungalow but were invited by a next-door neighbour to see hers which was identical. Access was easy with only one step up to the door and no steps inside. The neighbour said she could remember that the complainant's mother had bad eyesight although she could manage perfectly well in the bungalow. The neighbour said she had 'popped in' once or twice a day to make sure that the complainant's mother was all right and her relatives visited frequently. She said that the complainant's mother could make herself tea or cook a simple meal and could look after herself to some extent.

Findings

20. The decision of the consultant as to whether the complainant's mother was medically fit for discharge home was taken solely in the exercise of his clinical judgment and therefore not one on which I may comment. However it is clear that the arrangements he made for —— discharge were instituted in accordance with a considered plan and took account of her personal and social circumstances. I am satisfied that adequate enquiries were made and I do not uphold this complaint.

(b) *The complaint that the consultant applied undue pressure on the relatives and told the complainant's mother that her son would not allow her to be discharged*

21. The complainant said that his mother had been told that the hospital would like her to go home, but her son would not let her, and that this statement caused her great anxiety and distress. He told my officers that when the relatives had visited his mother on the ward, remarks had been made by the nursing staff that they should be welcoming her home to the family. He said he thought that his whole family had been 'bulldozed' by the doctors and the nursing staff and he was pretty sure that the latter were acting under instructions from the doctors. The complainant said that he accepted that if a patient was well and was taking up a bed then that should be brought to the relatives' attention. He and his brother were extremely angry that their mother had been told that she would have been discharged from the hospital but her family were unwilling to accept her. They thought that this was the sort of pressure which was completely unjustified and they wanted the consultant publicly censured for it.

22. The AHA in their reply of 18 June said that the doctors accepted that they tried to persuade the complainant and his family that their mother could return home. This was normal procedure where it was thought that a patient could cope at home with appropriate support. The AHA said that the complainant's mother asked to be allowed home and 'only after your mother's relatives refused to allow her to be discharged did [the consultant] inform your mother that she could not go home'. The AHA told me that they did not think that there was undue pressure placed on the complainant or his relatives, 'in view of the assessments that were made on the late Mrs —— and in the light of her own wish to be discharged'.

23. In a letter to the AHA in response to this complaint the consultant stated 'I make no attempt to conceal the fact that I told Mrs —— that the family would not have her home. She asked to be allowed home and after discussion

with occupational therapists, nursing staff and my juniors, I considered it a not unreasonable request. Only after the relatives refused did I inform the patient why she could not go home.'

24. The consultant told my officers that he could remember the complainant's mother asking him on either 10 or 16 March during a ward round why she could not go home. He said that he explained that her relatives would not have her home. She had reacted badly to this at first but he explained to her that they would do the necessary tests and she would still be able to be discharged with the correct social services support available. He told my officers that if a patient asked him he could not see that lying to her or making an excuse blaming the hospital would be good enough.

25. The HO told my officer that he could clearly remember talking to the complainant's mother about the disagreement over her discharge.

26. The sister told my officer that she could remember speaking to the nurses and the medical staff about the mother's specific request to go home. She recalled that the complainant's mother had been a little upset when told the relatives would not have her home, but recovered somewhat when told that with adequate social services support she could still go home.

Findings

27. There is no doubt that the family felt that they would be unable to give their relative proper care at home and that they made this clear to the hospital staff. The consultant had to balance their concern with his responsibilities to other patients. The fact that he reaffirmed his decision that she should go home, as she herself wished, does not in my view amount in the circumstances of this case to 'undue pressure'. It is regrettable that she should have been distressed by the knowledge that her family saw difficulties in caring for her at home, but I consider that the consultant acted reasonably and without malice in answering her direct question truthfully. I do not uphold this complaint.

(c) *The complaint that the house officer called the complainant's mother 'a stinking woman'*

28. The complainant said that when his mother apparently resisted attempts to give her a bath, a doctor told her that he 'does not want stinking women in his ward', which caused her great mental anguish.

29. The AHA told the complainant that the HO admitted that he was the doctor concerned but that to the best of his recollection he had said 'Come on, Mrs ——, we can't have dirty ladies on the ward.' The HO did not recall using the word 'stinking' on any occasion. The AHA said that although this description of events seemed innocent enough they deeply regretted the distress it caused.

30. The HO told my officer that he recalled the incident. The complainant's mother was reluctant to get out of bed to take a bath and he had said something like 'Come on Mrs —— we can't have dirty women on the wards'. He denied using the phrase 'stinking woman' and did not think he would ever use such an expression. He said the complainant's mother did not seem worried at the time, and continued to be reluctant to get out of bed. He said the words he used were

not meant to be insulting at all. The HO told me that taken out of context such a dialogue could sound extremely harsh, but that he was not aware at the time that it caused the complainant's mother mental anguish. He certainly did not intend to do so and was extremely sorry if he had.

31. The first SEN told my officers that she could recall the HO approaching the complainant's mother on one occasion to encourage her to wash, as she was sometimes very lethargic and reluctant to do anything. The first SEN said she did not recall any phrase like 'stinking woman'; the HO was a gentle doctor and he had been encouraging, not offensive in any way. The second SEN gave my officers the information recorded in paragraph 16.

Findings

32. I have not obtained any corroborative evidence that the phrase 'stinking woman' was used and I do not believe that it was. I accept the account of the episode given by the HO who has expressed his regret for any mental anguish if caused, even inadvertently, to the complainant's mother.

(*d*) *That the replies by the AHA to these complaints were unsatisfactory*

33. The complainant wrote letters of complaint to the consultant and to the AHA on 23 April 1979, enclosing notes on his complaint. The Area Administrator (the AA) sent an acknowledgement to him on 2 May. The AA telephoned the consultant and then wrote to him on 6 June asking for a report. The consultant replied on 11 June to the AA dealing with those aspects of the complaint which related to him and the AA wrote to the complainant on 18 June giving answers to many of the complainant's 16 points and telling him that he would give him more information as soon as he could. The same day the AA wrote to the District Administrator (the DA) asking for some additional information. The DA sent a reply to the AA on 8 August, apologising for the delay which he said was due to the complex issues raised and the fact that a report from the social services department had only just been received.

34. On 3 August the complainant replied to the AA contesting some points of fact, amplifying complaints and asking for more information as well as replies to his as yet unanswered points from his first letter. On 17 September the AA wrote to the complainant replying to his second letter and dealing with other points from his first letter. He explained that the delay in responding to the complainant's questions about the social services department was due to an oversight in his office, for which he apologised. He also said: 'Where statements made by staff conflict with those making complaints, the only method of ensuring a thorough and impartial investigation is to refer the matter to the Health Service Commissioner, which is an option that you have perhaps already considered.' He again promised further information when available. The same day the AA wrote to the HO, who had left the area. The HO replied on 19 September and the AA wrote to the complainant again on 27 September (see paragraph 29). This letter ended 'I have now completed my investigations and I hope you will accept that, in this letter and in previous correspondence, we have genuinely tried to answer the questions you have raised.' The complainant replied to this letter on 4 November. He sincerely thanked the AA and his staff for their 'obvious efforts' in investigating his complaints, which had satisfactorily

answered some points and acceptably answered others, but he felt there still remained certain areas of great inconsistency; and after enumerating these, he asked the AA to refer the complaint to me, which the AA did.

35. The AA told my officers that he had considered whether to have a meeting with the complainant. As the staff involved were in a number of centres within the Area he had not considered it a very practical proposition particularly as the complainant was a lucid, clear writer and the AA thought the matter could best be dealt with by correspondence. He said his enquiries at the district had covered medical, administrative and nursing staff as well as the social workers, and although he was aware the complainant was not satisfied with the content of the replies he had received he did not believe that the AHA could have done any more.

Findings

36. Although the complainant was unable to accept all the answers given to him he accepted that the AHA had made 'obvious efforts' to investigate his complaints. They frankly acknowledged, and apologised for, the delay in obtaining statements from the social services department, and also apologised for any distress to the complainant's mother over the alleged 'stinking woman' incident. I am satisfied that reasonable and comprehensive steps were take to answer all the complainant's queries and that the replies were full and courteous. I do not uphold this complaint.

Conclusion

37. I have given my findings in paragraphs 20, 27, 32 and 36. I can appreciate that, possibly because he was preoccupied with considerations of how his mother would be cared for if she was discharged home, the complainant found it difficult to accept that a decision to discharge her had been made in good faith and after full account had properly been taken of all the relevant circumstances. I believe it was and I do not uphold any of these complaints.

Case No. W.342/79–80 – Standard of nursing care and visiting restrictions

Background and complaints

1. The complainant's wife, aged 69, suffered a second stroke at the end of December 1978, leaving her paralysed on both sides and without power of speech. She was a patient in a hospital (the hospital) from March to August 1979. The complainant contends that:

(*a*) the standard of nursing care given to his wife was unacceptably low;

(*b*) he was subjected to unnecessary restrictions when visiting his wife;

(*c*) staff were rude to him and subjected him to harassment and intimidation; and

(*d*) the way that the Area Health Authority (the AHA) dealt with his complaints was unsatisfactory.

Investigation

2. During the investigation I obtained the AHA's written comments together with copies of the medical and nursing notes, statements made to the District

Nursing Officer (the DNO) and the DNO's report made to the AHA about the complaints as well as other relevant papers. One of my officers met the complainant and the medical, nursing and administrative staff concerned. The complainant's evidence in paragraphs 3, 4, 14, 15, 24, 33 and 35 below has been summarised from his letters to the AHA and me and from his interview with my officer.

(*a*) *The complaint that the standard of nursing care was unacceptably low*

3. The complainant said that he had been very worried and concerned about the nursing care given to his wife; although most of the nurses were excellent, this did not apply to a nurse in charge of an evening shift (the SEN) who had let his wife lie in urine for up to two hours from the time when he reported her wet. He complained to his wife's consultant physician (the consultant) and the ward sister (the sister) about this and about his wife's distress due to a bedsore, urine scalds and a rash. As a result of this complaint the sister 'had a word' with the SEN and things improved, although he felt that he was a 'marked man' on the ward as he had dared to complain. He said that a nursing auxiliary (the first NA) obviously did not like him but he did not think anyone employed as a nurse would be callous enough to take it out on a helpless cripple. He alleged that, whilst most of the regular nursing staff were on holiday, the first NA seemed to like to hear his wife screaming and delayed changing her when she was wet for periods of over an hour. On one occasion the first NA, knowing that his wife was wet, dealt with all the other patients in the ward and then went to tea, after which another auxiliary changed his wife. He also complained that the nurses had been careless about securing his wife's naso-gastric tube and that she had often been left leaning on the 'grid'-type bed backrest without any padding.

4. The complainant said that his wife had 'two whopping bedsores on the sacrum, an angry rash on her thighs and stank to high heaven' and that nothing was done about it because the ward was in charge of an unqualified nurse. He asked for the nursing officer to be called and he immediately arranged for treatment to be given. He added that he had noticed that when his wife was distressed as a result of poor nursing the senior ward staff were reluctant to call a doctor to prescribe the appropriate treatment.

5. As a consequence of his complaint the complainant, with the secretary of the local Community Health Council (the CHC Secretary) met the Administrator for Operational Services (the AOS) of the district with the DNO and agreed that the DNO should carry out an investigation. In a letter to the complainant which accompanied the ensuing report the AHA stated 'you will see from this report that the [DNO] is satisfied that the nursing care given to your wife was, and is, of a high standard, and whilst this may not be the individual personal attention you feel your wife requires, you can be assured that she is receiving devoted, considerate and competent care.' The letter went on to refer to a particular problem about his wife's catheter and said that despite many efforts a solution had not been found for it and the staff were doing their best to minimise the discomfort to his wife. The DNO told my officer that her investigation took over five weeks. She had examined the nursing records and called for ward reports and she built up what she thought was a complete picture from the nursing and medical staff and had asked the consultant for his observations. Her report stated that the complainant asked the nurses to change his wife whenever she

was wet, even if it was only slight, and that on one occasion the bed was changed four times in one evening. It said that on no occasion was his wife left more than half an hour and that complaints that she had been left deliberately were untrue, although occasionally other tasks were completed before she was changed. The wetness was due to the catheter leaking to which a solution could not be found. The report stated that she had had a rash on 6 April which cleared by 6 May. It also said that there was a small superficial bed sore on her left buttock from 2 May and that a second one appeared later. Both sores improved with treatment. The report went on to state that her naso-gastric tube was always taped in a position to prevent her removing it and that non-allergic tape was used; that she herself disarranged her pillows (and the complainant agreed that this was so); but that no one could recall her leaning on the bare backrest. In comments to me the AHA said that they 'strongly denied' the complainant's allegations.

6. The DNO told my officer that every incident described by the complainant had been investigated and she had found nothing in all her investigations to justify any of the complaints. She said that they had been very careful to maintain monitoring routines on the wards and had taken the precaution of keeping the complainant's wife away as much as possible from auxiliaries undergoing in-service training and junior nurses. The consultant told my officer that the complainant's wife had received exemplary nursing care and that when she left the hospital her pressure sores had disappeared.

7. The SEN has left the country and had nothing to add to the statement which she had previously made to the DNO. In this statement, which I have seen, she said that the complainant's accusation that she had left his wife wet for as long as two hours was totally untrue. The only time that his wife had had to wait to be changed was when staff were dealing with another patient, of whom there could be 24. She denied that the sister had 'had a word' with her, 'after which things improved'; this was confirmed by the sister who said that she had never had cause to speak to the SEN about her care of the complainant's wife. The DNO in her report said that she found the SEN when interviewed to be clear, frank and concise; she said that she had found no reason or cause to doubt her and felt the complaint against her was hurtful and unfounded.

8. The first NA told my officer that it was clear to her that the complainant had an intense personal dislike of her, which she thought stemmed from the fact that she had complained about him. In her statement to the DNO she said that it was quite untrue that she liked to hear the complainant's wife screaming. Every time the complainant told her that his wife needed changing she would finish the job she was doing and then immediately go to her. On one occasion when she had had instructions from the sister to deal with three other very ill patients first, the complainant's wife unavoidably had to wait about half an hour to be changed, but this was the longest time. She said that she did not go for tea before dealing with her; she would not walk off and leave the trolley in the middle of the ward, and in any event she would have had to wait for a relief nurse or be told by a senior to go for her tea. If another nurse had changed the complainant's wife it would only be when she was engaged on some other task or had been told to go for tea.

9. The DNO in her report said that no dates were given in respect of the complaint against the first NA and the complainant had not provided them when

requested. She said it appeared to her that the complaint was written retrospectively after the alleged hitting incident (see paragraph 14). Three pages of the DNO's report are taken up with the consideration of the complaints against the first NA and the DNO's conclusion was that the complainant's accusations against her appeared to be unfounded and indicated a complete misunderstanding of ward routine and a total disregard by him of the need to care for the remaining patients on the ward.

10. Many members of the nursing staff and a physiotherapist told my officer that the complainant's wife had received a very high standard of treatment; in fact, she had received better treatment than the other patients in the ward because the complainant had been demanding and they had been anxious not to upset him. They said that she had had superficial pressures sores but that these had cleared up with intensive nursing care. They also said that it had been difficult to keep her dry because her catheter leaked. The sister, agreeing with this, confirmed to my officer that on no occasion had the complainant's wife been left wet for more than half an hour although the nurses had other priorities. She said that they had had great problems with the complainant's wife's catheter, and sometimes she was a little wet. Many attempts had been made to solve this problem, but to no avail.

11. The medical notes show that on 23 March 1979 the complainant's wife had 'no obvious pressure sore (tiny broken area – on her buttock)'; on 17 May the notes record 'back sore healing satisfactorily', on 30 May they record 'two little superficial pressure sores over the sacrum', on 1 June 'very small pressure sore . . . healing'; on 3 June 'superficial sacral sores'; on 2 July 'pressure sore – healing 1 inch left buttock'; on 4 July 'pressure sore healing'; on 11 July 'bed sore . . . is healing slowly'; and on 8 August 'left buttock ulcer, very small, healing'. The patient's transfer form completed when she left the hospital on 16 August states 'small broken area on buttock, slight rash on thighs, heat treatment has been given to broken area on buttock, . . . cream applied to rash'.

12. The nursing notes, which cover 73 pages, show that the complainant's wife was doubly incontinent and that there was a continual problem caused by her leaking urinary catheter. They record routine washing, pressure area care and feeding and that on occasions she pulled out her catheter and naso-gastric tube. There is a report on 6 August that 'the top of her legs were very red and burning' and these patches are described as 'scalded' on 8 August. These areas improved after treatment. The entry for 2 July 1979 says 'has a small red area with top layer of skin removed on right temple region ?due to micropore [which held the naso-gastric tube in place] being tight and patient rubbing same area'. The notes also record several occasions when the complainant contended that his wife was wet or needed other attention, and that on one occasion he had complained that his very ill wife was next to a patient who had died.

Findings

13. I am completely satisfied that the standard of nursing care given to the complainant's wife was not 'unacceptably low', indeed I am impressed with the devotion that the nurses clearly gave to a patient who needed constant nursing care in difficult circumstances and in a ward which had a large number of patients requiring close nursing care. I reject this complaint.

(b) *The complaint about restrictions when visiting his wife*

14. The complainant said that two nursing auxiliaries had claimed that they saw him hitting his wife. As a consequence he had had an interview with the consultant and the senior nursing officer (the SNO). The consultant had told him that he had heard from two reliable middle-aged nurses, both mothers, who said that they saw him beating (or maybe hitting) his wife. The complainant said that that was 'about the foulest and most diabolical smear a sub-human can perpetrate' and he categorically denied it. He said that what had happened was that he had reported his wife wet and as usual started arranging her hair. When it was done he normally inserted a Kirby grip to hold it. At the time he was holding it in his right hand and trying to smooth her hair with his left prior to inserting the grip. When he bent over her, precariously poised between the bed and the locker, she reacted playfully to him and he responded as though playing with a kitten and with about the same force. He realised that a nursing auxiliary (the second NA) had seen a movement but she had been standing the full width of the ward away. She told him 'I saw you pulling your wife about.' At the end of the interview the consultant had told him that he must not touch his wife, do her hair, clean her nose, play ball with her, give her objects to pick up, in fact, the complainant said, he could do nothing which had previously helped her mobility and kept her amused and interested. He said that the allegations had been made as a counter-complaint after he had complained about his wife's care. He said that he had certainly called his wife a 'silly bitch', which he now regretted, but that he had not struck her at all. He said that the only time he had used the word 'mad' to his wife was in the context 'don't go mad on me'.

15. About a month after the meeting with the AOS and the DNO (see paragraph 5) but before the DNO's report was sent, the complainant on 29 July wrote a further letter of complaint referring to another incident. He said that his wife was wet and that he had told her that the nursing staff knew and that she would be changed as soon as possible. But when he told the sister she opened her mouth really wide and shouted 'How do you know your wife is wet?' and that he was somewhat taken aback by the uncouth manner of approach. He said that he replied that his wife had indicated that she was wet but the sister kept shouting like a fishwife that he had been told not to touch his wife. In a tape-recorded report the complainant said with reference to this incident 'I was not told that I could not have my hand under the bedclothes; what was I doing there? Was I behaving immorally?'

16. The DNO's report stated 'It is correct that [the consultant] requested the complainant to refrain from physiotherapy, feeding or combing his wife's hair when he visited, and this instruction only was relayed to the ward sister and, as she understood it, it was to prevent any further misunderstandings in regard to his "playing" with his wife.' The letter of 7 August from the AOS which accompanied the DNO's report said that the consultant wanted the complainant to continue to hold his wife's hand when he visited, but did not wish him to play any part in her therapy. The AHA told me that they strongly denied that the restrictions on visiting were unreasonable.

17. In his letter to the DA the consultant said that he had asked the complainant not to give his wife any physiotherapy nor any occupational therapy and that he wanted him to visit his wife and do nothing at all for her. The consultant said

that the complainant had resented this very much but that he had no doubt that his decision was correct because of the strange behaviour of the patient's husband. The consultant told my officer that he had heard that there had been incidents involving the complainant striking his wife and at a meeting on 6 June he had asked the complainant for an explanation. The complainant had said that he was helping to give her physiotherapy, as he had been invited to do at a previous hospital, and had described the incident as a minor one which had maliciously been given greater importance by the nursing auxiliaries because he had complained about them. The consultant said that he had told the complainant that he would prefer the physiotherapist to give the therapy and had said that the complainant should be a 'good visitor'. He had not at any time been specific about what the complainant must or must not do but he had asked him not to engage in nursing procedures with his wife.

18. The SNO, who was present at the meeting on 6 June, made a record of it the next day in which he said 'it was requested by [the consultant] that [the complainant] should refrain from physiotherapy, feeding or combing his wife's hair when he visited'.

19. The sister told my officer that she remembered the instruction from the consultant and that as far as she was concerned the complainant was not to touch his wife at all as it was open to misinterpretation when he did. In her statement to the DNO she said that on 13 June she spoke to the complainant in her office asking him not to touch his wife. He denied having been told by the consultant that he was not to do anything for his wife, but was very pleasant and agreed to what she had asked.

20. The first NA and the second NA told my officer that they had witnessed the complainant striking his wife on 19 May. The first NA said that she was clear in her own mind that he had struck her and had not been playful with her. She said that he was standing over his wife and as she raised her arm towards him he struck it a number of times and kept striking it. She did not think he had seen her observing him and he left in a temper. The second NA said that the complainant had been holding his wife's arm and banging it up and down. She said that the sister had told her that he was not to touch his wife at all.

21. Four other nurses told my officer that they had been told that the complainant should not be allowed to touch his wife. They all knew that restrictions had been imposed because of the allegations that he had hit his wife. Most of them felt that he should not be totally restricted, and allowed limited contact under supervision.

22. The nursing notes contain an entry for 19 May, signed by the first and second NAs, that 'The complainant was seen by two nurses at 6.30 pm smacking and shaking his wife. He was approached and asked to leave her alone. He denied incident'. There is no mention of bruising in the nursing record until 27 May, when an entry reads 'has two small bruises on right forearm'. By 6 June these bruises were subsiding and were described as 'slight'. The first reference to the restriction is on 7 June when the complainant's adverse opinion about it is recorded. On 13 June there is a record that the complainant was asked by the sister 'not to do things for his wife'. There are similar references to the restrictions on 23 June, 3 and 28 July and a reference on 24 June refers to his being

'unable to touch his wife'. On two occasions it is recorded that he left the hospital early because he had been told not to touch his wife or attend to her personal hygiene. Other entries in the nursing notes refer to his becoming agitated and shouting at his wife and calling her names, including one occasion when he told his wife she was mad and called her a stupid bitch to which she reacted by crying. After a chat with the nurse he calmed down and the rest of his visit was quite pleasant.

Findings

23. I am not satisfied by the evidence that the complainant struck his wife. But I am quite satisfied that the staff caring for her honestly believed that he did. They were led to this belief by his bizarre actions and his admitted verbal abuse of her. That being so, there is no ground for criticism of the restrictions imposed by the consultant on the complainant's visits to his wife, which were the result of reports made to him by his staff. The sister however seems to have interpreted the consultant's instructions in a sense even more severe than he intended: but it matters little, because the ward staff for their part interpreted the instructions fairly liberally. But I cannot uphold the complaint about a misfortune of which the complainant was largely himself the author.

(c) *The complaint that staff were rude and harassed and intimidated the complainant*

24. The complainant said that as he was a drug representative, he had a wide knowledge of how nursing procedures should be carried out. He thought that because he was visiting every night he had become something of a nuisance to the nursing staff and that as he had made complaints about the nursing care his wife had received, the ward staff had tried to harass and intimidate him, and had been rude. He said that he was the sort of visitor that wanted to be involved as much as he could but did not agree that he interfered with nursing procedures. He said that in his wife's previous hospital he had been considered a useful member of the rehabilitation team, and was properly instructed and encouraged to feed his wife by tube and, with a small spoon, to try to get her to take coffee by mouth. He said that he had even written the amounts of fluid she was taking on the fluid intake chart. He found the lack of standardisation of nursing procedures from one ward to another confusing, as he was sure that his wife must also have done. He said the staff had given him hostile looks.

25. The DNO's report stated that no member of the nursing staff at his wife's previous hospital ever instructed the complainant in the techniques of tube feeding. It stated 'the fact [the complainant] lodged a complaint was not entirely unexpected as he had expressed very forcibly but informally his dissatisfaction with his wife's care at [a previous hospital]. It was for this reason that staff at [the hospital] were advised by the Divisional Nursing Officer (the Div NO) to give serious regard to any dissatisfactions he may have about his wife's care, record them in the [nursing record], and seek advice if necessary from their Nursing Officer'. The report stated that the complainant had not been harassed or intimidated by nursing staff; he had been treated with a great deal of forbearance, tact and understanding. In their comments to me the AHA strongly denied the complainant had been harassed.

26. A sister from the complainant's wife's previous hospital told my officer that staff had tried to involve the complainant in his wife's care as much as was

reasonable as he would interfere in any case, and it was thought best to try to channel this interference into something useful. It was true that the complainant, if giving his wife a drink, would mark it down on the fluid intake chart, but he would do this whether he was told to or not, so it was best to keep him happy by letting him do it. Both this sister and a nursing officer from the previous hospital told my officer the complainant had made complaints and upset the nursing staff there. The patient's transfer form sent from the previous hospital to the hospital noted, in part, that the complainant 'is a very demanding gentleman and, at the slightest provocation, made complaints about [his wife's] care. He has an aversion to learners especially the more junior and at times became extremely verbally abusive'. The Div NO told my officer that she had advised the nursing staff at the hospital to make careful notes of any incident. She said that the SNO had talked to the trained nurses explaining that the complainant was a difficult man to deal with but it was his concern for his wife that made him so anxious. The SNO told my officer that he did not think that this warning had prejudiced the nurses against the complainant from the start.

27. None of the staff felt that the complainant had been harassed or intimidated and they denied being rude. On the contrary, in statements to the DNO the sister said that she had allowed the complainant to give his wife naso-gastric foods and perform her oral hygiene after instructing him and observing him. He objected to this as he said that he had been instructed at his wife's previous hospital. To save any further aggravation, the sister said that she had changed the wife's feed times on 4 May. She also said that on several occasions the complainant had called his wife names, and two nursing officers said he made derogatory remarks about the SEN and the first NA. Some of the staff commented on the strain on the complainant of regular visiting, having to travel a long way after work each day. However, all the ward nurses made remarks to my officer which showed that they disliked and mistrusted him – one said he was 'a sick man who was very short-tempered' and another said he was 'the strangest man' she had ever met. The SNO told my officer that as the time for his arrival neared, the anxiety of the staff on the ward was discernible.

28. The tone of the nursing records are in no way antagonistic to him, but some entries do show the complainant's attitude; for example on 5 April he was described as being 'in an agitated and aggressive mood', on 30 May he was said to be 'rather demanding and complaining about nurses', and on 12 June it was reported that he 'accidentally? knocked over vase'. However, the vast majority of the entries either note his visits without comment, or say that he was polite and uncomplaining.

Findings

29. There is no doubt that the nursing staff resented the complainant's attitude and the complaints he made about them and disliked him because they believed that he had hit his wife. However, I can find no evidence that the staff were rude to him or that they intimidated or harassed him, although I suspect that on occasions their attitude to him must have been plain. I do not uphold this complaint.

(d) *The way that the AHA dealt with the complaints*

30. The complainant first complained about his wife's care at a meeting with

the consultant and the sister on 2 May 1979 and he had another meeting with the consultant (who was then accompanied by the SNO) on 6 June. On 7 June the complainant wrote to the AHA to complain about his wife's care and the restrictions that the consultant had put on him when visiting. The AHA sent his letter to the District Administrator (the DA) for him to reply to the complainant. On 24 June he wrote to the AHA again, complaining of harassment and intimidation by the hospital staff.

31. On 30 June the complainant, accompanied by the CHC secretary met the AOS and the DNO. The complainant clarified some points in both his letters and after discussion he agreed that the DNO should investigate his complaints. On 29 July he wrote again to the AHA, complaining about further harassment by the sister the previous day (see paragraph 15).

32. The DNO's report, comprising 21 pages, was sent to the complainant on 7 August together with the AOS's letter, which also said that the complainant could discuss the reply with the consultant, the DNO and the AOS at a meeting on 10 August. However, the complainant did not attend the meeting but instead wrote to the Area General Administrator (the AGA) on 9 August that 'in view of the "botched up" District level inquiry, I formally apply to you for an independent AHA inquiry to probe into my complaints'.

33. The complainant said that the DNO's investigation had been inadequate; it had attached undue importance to certain nursing procedures, had ignored some of his complaints and did not deal with the underlying problems. He also felt that the DNO was being unrealistic if she expected that the nurses would admit to her that they had been at fault. The complainant said that when he had asked for an independent inquiry he had wanted one independent of the AHA.

34. The AGA replied on 10 August that, in view of the serious nature of the complaint, the chairman of the AHA had authorised the setting up of a Committee of Inquiry to investigate and report to the AHA, and that as soon as the constitution and terms of reference of the Committee had been established the Area Administrator would be in touch with the complainant. On 21 August the AGA wrote again to say that two members of the AHA would comprise the Committee, and this was acknowledged by the complainant on 23 August. On 29 August he notified the complainant that a senior nurse manager from another Region had been added to the membership of the Committee. The complainant acknowledged receipt of this letter on 3 September when he also asked to be informed as to the precise terms of reference for the Inquiry. The AGA wrote to the complainant on 4 September saying that the Committee of Inquiry would be set up under paragraph 7(iii)(*a*) of circular HM(66)15 'to investigate the complaint of —— and to report'.

35. On 18 September the complainant and the CHC secretary attended the inquiry. The complainant said that he had requested an independent AHA inquiry, and instead, he got a 'homegrown' one. He said that he registered a protest, but agreed to the AHA inquiry without prejudice. He said that when the inquiry was convened the chairman opened the proceedings and the rest was promptly 'torpedoed' by an official of the Royal College of Nursing, who stood up from the audience and demanded an independent AHA inquiry. The chairman, 'faced by no less than a vociferous union official, thought discretion the best part of valour' and adjourned the inquiry.

36. I have seen the correspondence between the complainant and the AHA about the constitution and terms of reference of the Committee of Inquiry. There is no record that the complainant registered any protest before the inquiry itself. The proceedings of the inquiry were recorded in shorthand and I have seen a transcript. At the start of the proceedings the CHC secretary explained that the complainant had wanted an inquiry under Section 7(iii)(b) of the Circular, which provides for an inquiry with membership independent of the AHA concerned. After a recess to consider the matter the chairman pointed out that the complainant had been advised on 4 September under which paragraph the inquiry would be held and who would comprise the Committee of Inquiry. It appeared to him that the complainant had had sufficient time to raise this matter before, but if he felt it was not fair the complainant would have to raise the matter with the Authority, although the Committee were still prepared to go on. At this point the regional officer of the Royal College of Nursing asked to speak. He said that they were surprised that the complainant had left it so late to raise an objection to the formation of the Committee, and they would like to register their protest at this lateness. They were not prepared to go through with the inquiry as then laid down, because they felt that if they did so their members might well be subjected to a further inquiry, which they were not prepared to allow. The inquiry was then closed.

37. When the AHA received the report of the Committee of Inquiry they decided that the matter should be referred to me for investigation, but I had to tell them that in accordance with the Act which defines my powers they could only refer a complaint to me within three months beginning with the day on which they had received the complaint and that that day had passed shortly before they referred it to me. The AHA told the complainant of my decision and said that if he decided to pursue his complaint he should write to me, which he did.

Findings

38. After a meeting with the complainant to discuss his complaints it was agreed that they should be investigated by the DNO. The lengthy report she produced was not acceptable to the complainant, who declined the opportunity to discuss the DNO's report with the consultant, the DNO and the AOS. The complainant asked for an independent inquiry; he was informed that the inquiry would be set up under paragraph 7(iii)(a) of circular HM(66)15 and that two AHA members together with an independent senior nurse manager would be involved. Yet he waited until the morning of the inquiry before saying that he wanted an inquiry under the terms of paragraph 7(iii)(b) of the circular. In all the circumstances there could be no point in going on with the inquiry as then constituted. The AHA then tried to refer the matter to me, and after I advised them of a time bar, suggested to the complainant that he write to me direct, which he did. In these circumstances I do not see what more the AHA could do, and I do not uphold this complaint.

Conclusion

39. I have set out my findings in paragraphs 13, 23, 29 and 38. The complainant was unreasonable in the demands he made continually upon busy staff for immediate nursing attention to his wife. He himself wanted to help but his

manner was open to misinterpretation and some of his remarks left much to be desired. Wrongly convinced that he was being victimized, his frustration increased and his complaints became exaggerated, much to the chagrin of staff and AHA. As a result, relationships were strained. I am however completely satisfied that his wife was well cared for and I hope that the complainant will feel able to accept this assurance.

Case No. W.388/79–80 – Care and treatment prior to husband's death

Complaint and background

1. On 3 December 1979 the complainant's husband was admitted to hospital (hospital A) where he underwent several tests. On 11 December he was taken to another hospital (hospital B) for a body scan and on 14 December he returned there for a bronchoscopy. He remained at hospital B until 17 December when he returned to hospital A where he died the following day.

2. The complainant contends that:

(*a*) on 13 December a consultant physician (the consultant) told her of the seriousness of her husband's condition in an abrupt and unsympathetic manner and that afterwards no member of the hospital staff offered her comfort or satisfied themselves that she was fit to travel home;

(*b*) when her husband was transferred to hospital B on 14 December he was left unattended for a considerable period in a public corridor;

(*c*) on 14 December he was without his prescribed drugs for more than five hours at hospital B;

(*d*) although the consultant claimed that he had explained the husband's diagnosis to him by 13 December he did not in fact do so until 18 December and then no member of the medical staff was available to answer his questions about his deteriorating condition; and

(*e*) the Area Health Authority (the AHA) failed to deal with her complaint satisfactorily.

Investigation

3. During the investigation I obtained the AHA's comments and have examined these together with the medical and nursing records and other relevant documents. One of my officers interviewed the medical, nursing, and administrative staff concerned and he also met the complainant and spoke to the friend (who was a doctor) who had accompanied her to hospital A on 13 December.

(a) *The complaint about the consultant's manner and the lack of concern by hospital staff on 13 December*

4. In her letter of complaint and in her interview with my officer the complainant said that the consultant had asked her to see him at hospital A on 13 December and on her arrival, accompanied by a friend, she was shown to the ward sister's office and informed that the consultant's ward round was in progress. After a few moments the consultant appeared in the doorway and without entering the room announced that it was then 99 per cent certain that the complainant's husband had lung cancer, although there was still one test to be made for final confirmation. He said that the husband's metabolism had 'gone

haywire', he was confused, and he was being moved into a private room. The complainant said that after a pause her friend introduced herself and had asked a medical question to which the consultant gave a brief reply and then disappeared. The complainant said that she was badly shocked by what the consultant had said and that after he left no nurses came to comfort her or make sure she was fit to travel home. Shortly afterwards she and her friend left. The friend told my officer that on arrival a pleasant ward sister had shown them into her office where they had waited for five or ten minutes. She confirmed the complainant's description of the conversation with the consultant and said that although he was not rude or abrupt he was nevertheless 'to the point'. She thought that the interview had lasted about five minutes and said that it had also included some general questions from the complainant to which the consultant had responded.

5. In his reply to the complaint the general administrator (the GA) said the consultant certainly did not intend to upset the complainant in any way but it was accepted that she must have been shocked. He said that the nursing staff considered it their role to comfort distressed relatives but unfortunately the ward sister was unaware that the sad news was to be broken to the complainant during the ward round. She was therefore unable to prepare her for the shock and the nursing staff had not been able to comfort her afterwards as she had left. The ward sister told my officer that had she known that the consultant intended to tell the complainant of her husband's prognosis she or one of her staff would have been ready to comfort her. She said that such action was their regular practice and that medical staff usually warned the nursing staff beforehand.

6. The AHA told me that the consultant did tell the complainant that her husband almost certainly had lung cancer but the result of one final test was necessary. The consultant did not think he had been abrupt but acknowledged that the ward was particularly busy when the interview took place. The consultant told my officer that on 13 December he remembered breaking off from a busy ward round immediately he was told the complainant had arrived in order to speak to her. He could not recall exactly what was said, or where he stood, but he said that he spent enough time with her to respond to several questions, at least one of which came from the friend. He was sorry if his attitude had been interpreted as abrupt but he did not think that he had been other than sympathetic. He had regarded the complainant as a strong-willed and intelligent woman who had expected this bad news but in retrospect he thought that he had probably not judged correctly what a shock it would be to her. He said that some relatives would become very emotional on hearing such news and he would prepare the nursing staff accordingly, but at the time he had no reason to believe that this would be necessary in the complainant's case.

Findings

7. The consultant did not expect the news of her husband's prognosis to affect the complainant as deeply as it did and consequently he did not warn the nursing staff to be ready to help her. This admitted failure was unfortunate, but the nursing staff were not responsible for it. I accept the consultant's assurance that he had not intended to be abrupt or unsympathetic and he has asked me to apologise on his behalf if that was the way he appeared, which I gladly do.

(b) *The complaint about the complainant's husband being left in a corridor at hospital B on 14 December*

8. In her letter of complaint and to my officer the complainant said that she was told on 13 December that she could accompany her husband to hospital B the next day and she did so. They were taken by ambulance at about 9 am but no nurse travelled with them and on arrival at hospital B the husband's stretcher was placed on the floor in a corridor, near some metal doors which clanged continuously, despite a 'filthy ineffective rag' to quieten them, and bundles of laundry were passed over her husband into a cupboard. The complainant said that there was no one there to whom she could speak and after about ten minutes two porters arrived and said that her husband was to be taken to the ward (ward Y) but on arrival there a nurse told them 'without apology' that another patient admitted as an emergency had been given the bed, and the nurse blocked the ward entrance. She did not give them any other explanation or help. The complainant's husband was then placed outside the ward beneath some open windows and one of the porters followed the nurse into the ward, from which he re-emerged after some 20 minutes to say that the patient was to go to another ward (ward Z). There was no communication from nursing staff during this time.

9. In his reply to the complainant the GA said that on his arrival at hospital B the complainant's husband was placed in the entrance corridor of the temporary accident and emergency department as there was insufficient room for him in the main section. He said that the need to keep the corridors clear explained the diligence shown in putting away the laundry although he apologised if it was 'tossed' in the way the complainant described. He said he had ascertained that there was no 'filthy ineffective rag' on the doors but that they had been neatly silenced with sticking-plaster and padding. He said that when a bed had been booked in ward Y for the complainant's husband the nursing staff had advised the admitting doctor that possibly this would not be available and it was understood that he would if necessary have to make alternative arrangements for admission to another ward. At 9.30 am on 14 December the admitting doctor was informed that there was no bed available in ward Y and when shortly afterwards the complainant and her husband arrived, the situation was explained to them by the sister and the staff nurse. The admitting doctor told the nurses that he was waiting to hear from another ward and the complainant and her husband were advised accordingly. Shortly afterwards the admitting doctor said that the complainant's husband was to be admitted to ward Z and the complainant and her husband were told and apologies were made. The GA told the complainant that the staff nurse who met them on ward Y did not think she had been abrupt or aggressive and he said that the AHA would be very concerned if such an unhelpful attitude had been adopted.

10. The AHA also told me that due to repairs to the normal accident and emergency department it had been necessary to use an inconvenient and cramped ground-floor ward temporarily to avoid having to close the department altogether for almost two years. They said that hospital B had a very high level of emergency admissions and was frequently short of beds, but had the purpose-built department been in use at the time, the complainant's husband would undoubtedly have had a more comfortable waiting period.

11. The staff nurse on ward Y told my officer that the admitting doctor had

been told that there was no bed available for the complainant's husband and that on arrival the husband, who seemed very ill, was on an ambulance trolley which was placed within the ward entrance vestibule. (My officer saw that the vestibule had wooden doors to the corridor.) The staff nurse greeted the complainant and her husband and explained the situation and telephoned the admitting doctor again to stress how ill the husband was. The doctor said that he thought that he had arranged a bed on another ward and would telephone her when this was confirmed. After five minutes she again contacted him and soon after he told her that a bed was available on ward Z; she immediately instructed the porters accordingly. The ward sister on ward Y told my officer that both she and the staff nurse were concerned about the complainant's husband's condition on arrival. He had been offered, but declined, a drink and the complainant was kept informed of events.

12. The admitting doctor told my officer that he could not remember the particular difficulty in finding alternative accommodation for the complainant's husband but commented that hospital B was always busy and there was no way in which booked beds could be guaranteed due to the high number of emergency cases. The chairman of hospital B's medical staff committee told my officer that during the winter months there was continuous and heavy pressure on beds at hospital B and explained the steps being taken to alleviate the problem.

Findings

13. I find that the arrangements for the transfer of the complainant's husband from hospital A to hospital B and for his reception there fell well short of an acceptable standard and caused the complainant and her husband unnecessary additional distress. I uphold this complaint.

(c) *The complaint about the delay in providing prescribed drugs*

14. The complainant said that her husband was treated with humanity in ward Z. He was put to bed and made comfortable but by noon he was becoming restive and experiencing pain because the effect of the drugs administered at hospital A was wearing off. She asked a nurse whether the pain could be relieved and was told that a doctor was coming. A little later, as her husband was becoming very uncomfortable, she repeated her request and the nurse told her that because the drug sheet had not accompanied the patient she would have to telephone hospital A to obtain details and also reiterated that a doctor was on his way. The complainant said that a doctor arrived at about 2 pm. After examining her husband he administered some medication and said that the bronchoscopy would take place at about 3 pm.

15. In reply to this complaint the GA told the complainant that there had been a lack of communication between the hospitals and the position had been aggravated because the admitting doctor had been unable to see the complainants husband as soon as he arrived on ward Z. The AHA told me that this was because the doctor was dealing with patients requiring emergency treatment. They also told my officer that in retrospect and in view of his condition a nurse should have accompanied the patient to hospital B.

16. The staff nurse on ward Z told my officer that the complainant's husband arrived there at about 10 am following a telephone call from the admitting

doctor. She said the complainant's husband was put to bed and although it was not normal ward policy his wife was allowed to remain with him. The staff nurse said that she then telephoned the admitting doctor who said 'he would be down' but as he had not arrived by about 11.15 am and the complainant's husband was experiencing increasing pain she called him again. He said that he was dealing with an emergency but would come as soon as possible and she explained this to the complainant. Soon afterwards the complainant told her that her husband was most distressed and in need of something pain-killing. The staff nurse said that she then telephoned hospital A to establish the husband's drug regime as she had discovered that his drug sheet had not accompanied him; she explained to the complainant however that even with this knowledge she could not administer any drugs until the patient had been examined by the admitting doctor whom she telephoned again at about 12.30 pm. He said that he was still delayed in the accident and emergency department. He arrived at about 1 pm.

17. The admitting doctor told my officer that although the bronchoscopy was not planned to take place until 3 pm it was necessary to admit the complainant's husband during the morning to enable a full examination and certain administrative procedures to be carried out. The doctor said that on 14 December he was very busy as he was responsible both for emergency cases in the accident and emergency department and for three other patients requiring bronchoscopies that day. He remembered at least one call from ward Z to say that the complainant's husband was in pain but said it would have been inadvisable to prescribe by telephone for a patient he had never met and whose medical history he did not know. As it was his responsibility to deal with these particular patients it would not have been usual to arrange to send another doctor except in a major emergency. He said that he saw the husband as soon as was practicable, which was at about 1 pm, and after a full examination, he prescribed pain-killing drugs. I have seen from the drug prescription sheet that this was at 1.50 pm.

Findings

18. The complainant's husband was certainly without drugs from the time he left hospital A at approximately 8.30 am until 1.50 pm. But I am satisfied that the nursing staff on ward Z who could act in the matter only on medical instruction, kept the admitting doctor and the complainant informed. The decision which the admitting doctor took about the priority he should give to the complainant's husband when he had other patients to care for is one he made, in my opinion, solely in the exercise of his clinical judgment, and therefore not a decision I can comment upon.

(d) *The complaints about the date on which the consultant told the complainant's husband of his diagnosis, and that when he was told, there was no doctor available to answer his questions*

19. In her complaint to the administrator (the HA) of hospital A the complainant said that she received a telephone call at her home from the consultant during the morning of 18 December to say that tests (see paragraph 4) confirmed that her husband had cancer of the lung and that he had contracted pneumonia. The consultant also said that he had told the husband of the diagnosis. The complainant said that she immediately went to see her husband who asked her various medical questions to which she could not reply. She asked the HA why

a doctor who knew about the case was not available to answer them. In his reply to the complaint the GA said the consultant had told the husband of the diagnosis prior to seeing the complainant and her friend on 13 December. The complainant replied that this was untrue because her husband had been told only after the result of the bronchoscopy was known.

20. The AHA told me, and the consultant later confirmed to my officer, that the complainant's husband was not in fact told until 18 December. The consultant said he was responsible for this error when responding to the original complaint and that he wished to apologise for the mistake. The consultant told my officer that he personally had made the arrangements for the bronchoscopy direct with a colleague at hospital B and had maintained close contact with him whilst the complainant's husband was in hospital A. To avoid delay he had telephoned the pathologist at hospital B on 18 December to obtain the results and had immediately spoken to the husband whom he knew to be an intelligent person who would wish to know exactly what was wrong with him. The consultant said he spent at least 10 minutes with the husband who had asked several questions and soon afterwards the consultant telephoned the complainant at home. He said that both he and his registrar were readily available to discuss any other questions raised by the complainant or her husband.

Findings

21. I uphold the complaint about the date on which the complainant's husband was told of the diagnosis but I am satisfied that the error was made inadvertently and the consultant has apologised for it. I am also satisfied that the consultant or another doctor was available and willing to answer any further questions by the complainant or her husband if requested and I do not therefore uphold this aspect of the complaint.

(e) *The AHA's handling of the complaint*

22. On 14 January 1980 the complainant wrote to the HA complaining about several aspects of her husband's care and treatment at both hospitals. He asked the consultant and the principal nursing officer for their comments. He also sent a copy of the complainant's letter to the GA who told him that he would reply and asked him and the sector administrator (the SA) of hospital B for reports. The HA sent the comments of the consultant and the principal nursing officer to the GA on 1 February. The SA, having obtained the comments of the consultant responsible for the bronchoscopy and of the two staff nurses, and having also discussed the case with the senior nursing officer, wrote to the GA on 31 March enclosing copies of the comments he had received.

23. The GA sent the complainant an interim reply on 21 March and on 21 April she wrote to the SA to ask when she could expect a reply and he told her that the GA would be replying shortly. On 30 April the GA telephoned her to confirm this. After further enquiries of the ward sister at hospital A the GA sent a full reply on 19 May. On 27 May the complainant replied thanking the GA for the trouble he had taken in compiling his report but expressing her continued dissatisfaction. A meeting was then arranged between the GA, the Divisional Nursing Officer (the Div NO), the assistant SA from hospital B and the complainant. This took place on 17 June and following a discussion of the com-

plainant's particular complaints it was agreed that a further meeting should be arranged between her and the Div NO to explore the possibility of using volunteers to provide additional care and support for relatives. On 25 June the complainant wrote to the Div NO summarising her view of the meeting and making some additional comments to which the Div NO replied on 22 July and confirmed that their meeting had been arranged for September. The AHA told me at the conclusion of my investigation that the proposed voluntary support scheme, which was not yet in being, was in the first instance intended for relatives already bereaved rather than those distressed by the prospect of bereavement.

Findings

24. I consider that the AHA's investigation was thorough and that they replied fully to the complainant albeit with a mistake for which they were not responsible (see paragraph 20) and that after failing to satisfy her in writing they arranged a meeting to try to resolve her outstanding complaints. I do not uphold her complaint about the way in which the AHA dealt with them.

Conclusion

25. I have given my findings in paragraphs 7, 13, 18, 21 and 24 and the AHA have asked me to convey in this report their apologies to the complainant for the shortcomings I have found, which I gladly do. I am also pleased to record that the AHA have told me that the accident and emergency department is now in permanent and improved accommodation and that steps are being taken to alleviate the problems arising from the pressure on beds. I hope that the complainant will regard these developments as evidence that her complaint will bring benefit to others.

Case Nos. W.432/79–80 and W.1/80–81 – Transfer and discharge of psychiatric patient

Background and complaint

1. During 1978 the complainant was receiving treatment from her family practitioner and on 25 August of that year she saw his partner (the FP) at his surgery. At his suggestion she agreed to be admitted to hospital (the first hospital) Soon after arrival there she was transferred to another hospital (the second hospital) where she remained until 7 September. She complained through her Member of Parliament that:

(*a*) she was not seen by a doctor at the first hospital and was transferred to the second hospital against her will and with insufficient reason;

(*b*) her request to be discharged from the second hospital was not acted on with any sense of urgency; and

(*c*) she was dissatisfied with the response of the Area Health Authority (the first AHA) to her complaints.

Investigation

2. During the investigation the comments of the first AHA were obtained together with those of another Area Health Authority (the second AHA) in whose area the second hospital is situated. I have also seen the relevant corres-

pondence and the clinical and nursing notes. My officer discussed the complaint with medical, nursing and administrative staff concerned, an official of the Regional Health Authority concerned, and with the FP; he also met the complainant.

(a) *Examination at the first hospital and transfer to the second hospital*

3. In discussion with my officer and in correspondence, the complainant said that she was planning to go away on Friday 25 August for the weekend. She telephoned the FP to enquire whether her family practitioner, whom she had tried to see in the middle of the month, was back from holiday. The same afternoon she was surprised to find that the FP had called at her home and had left a note suggesting that she come to see him at his surgery. She drove there in her car intending to stop there briefly and then go straight on with her journey. She talked to the FP for about half an hour and remembered him saying that she looked as if she had not slept well recently and that she would benefit from a night's rest at the first hospital, rather than undertake a long journey. She added that the FP said he would visit her there the following morning. The complainant said that she could understand his reasoning although she felt reluctant to accept his advice. But she drove to the first hospital having first declined his offer to leave her car at his surgery. The FP followed her there in his own car. The complainant said that she thought that she went to the reception desk at the Accident and Emergency Department (the A and E Department) of the first hospital and explained that she was coming in for a night's rest on the recommendation of her doctor. She was asked to wait in a day room and some fifteen minutes later a nurse came and told her to get her belongings from her car as it was necessary to transfer her by ambulance to another hospital. The complainant thought the nurse was referring to an annexe of the first hospital and it was for this reason she went voluntarily into the ambulance. She said no one explained where the other hospital was or the reason for the transfer. She told my officer she was quite sure that during the short time she spent at the first hospital she was not seen by a doctor. She added that when she saw the consultant psychiatrist at the first hospital (the first consultant) on a subsequent occasion, he was amazed that she was transferred to the second hospital without him seeing her.

4. The FP told my officer that in his clinical view the complainant would be helped by going into the Psychiatric Wing at the first hospital. She agreed to go there and at the A and E Department they saw a woman who was the Senior House Officer in Psychiatry (the SHO). He was present at the interview between the SHO and the complainant and he only left after they all walked to a psychiatric ward. The FP believed that the complainant was to be admitted to the first hospital under the care of the first consultant. He denied that he told the complainant that she needed to go to the first hospital for one night only or that he would visit her there.

5. The SHO said that she was working as a locum Senior House Officer in Psychiatry at the first hospital at the time. She recalled interviewing the complainant in the presence of the FP in order to obtain a psychiatric assessment. Following the interview she decided that the complainant should be admitted to a psychiatric ward at the first hospital but she was then advised by nursing staff that the complainant's home was situated outside the catchment area of the hospital. She therefore referred the complainant to the second hospital. She

prepared a referral letter which, she said, she could not have written without seeing the patient. But she confirmed to my officer that she did not know the location of the second hospital as she had only recently moved to the area. The SHO was uncertain whether it was she or a nurse who explained to the complainant the reason for the move but she remembered discussing the transfer and obtaining from the complainant her agreement to being admitted to the second hospital as a voluntary patient. The SHO said that she had in the past been mistaken for a nurse and this might have been the case on this occasion.

6. The first consultant felt it unlikely that he would have expressed amazement that the complainant had been transferred without seeing him; on the contrary, he said, it was quite correct for her to be moved to the second hospital as she lived in its catchment area. He imagined that the FP was unaware of the situation when he escorted her to the first hospital. But he also said that had he himself been at the hospital at the time and seen the complainant, he would probably have admitted her, notwithstanding the catchment area constraints.

7. An official of the responsible Regional Health Authority confirmed to my officer that the catchment area arrangements were such that the second rather than the first hospital was the correct one to admit the complainant.

8. The first hospital could not trace any clinical notes about the complainant's visit there on 25 August but I have seen that the clinical notes at the second hospital include a referral letter from the SHO describing the complainant's condition and saying that she agreed to be admitted 'voluntarily'. The admission documents, clinical and nursing notes also record that she was admitted informally.

Findings

9. The evidence clearly shows that the SHO saw the complainant at the first hospital, that the complainant gave her agreement to her informal admission to the second hospital, and that, in terms of catchment area, it was the correct hospital to which she should have been admitted. Accordingly, I do not uphold her complaints as they were put.

10. But I can well understand why she complained. She was undoubtedly confused at the time and transfer arrangements that were both unexpected and not initially explained to her – since it is apparent that neither the FP nor the SHO understood the situation – must have added to that confusion. She should have been left in no doubt about the reasons for the transfer and about the location of the second hospital when, through no fault of her own, she had first attended a hospital in whose catchment area for psychiatric purposes she was not resident.

(b) *The request to be discharged from the second hospital*

11. The complainant said that she felt uneasy when she found herself at the second hospital and her fears grew when she saw a nurse making an inventory of her clothing. She told a nurse that she wished to leave the hospital and return to her car but was advised that this was not possible, and should she try to leave the police would be called to stop her. On 31 August she went into the local town and discussed her predicament with a solicitor who helped her to write a

letter requesting her immediate discharge from the hospital. This, she said, she presented to the Chief Medical Superintendent at the hospital who subsequently told the ward sister that the complainant was to leave as soon as possible. But she was disappointed to discover that this could not be arranged until she was seen by the consultant under whose care she was while at the second hospital (the second consultant) and she was not discharged until a week later (7 September).

12. The nursing records provide a daily account of the complainant's stay at the second hospital. On admission on 25 August she was described as 'co-operative' and there is no record of any desire to be discharged until 29 August when the nursing note says 'determined to leave the hospital, seen by [second consultant] and placed under Section 30 of the Mental Health Act'. On 31 August it is recorded that the complainant took a written request to be discharged to a named doctor but was persuaded to return to the ward and remain there until she was seen by the ward doctor. On 1 September, according to the nursing notes, the complainant told the nursing staff that she had booked a hotel room for the night but was persuaded to telephone the hotel and cancel the booking. The note for 2 September records that she was 'Regraded from Section 30 to Informal status', and the daily ward sheet for that day also records that change in status. On 3 September it is recorded that she was willing to stay in hospital. But the note for 4 September states 'Still refusing to take her prescribed medication. Says she feels ready for discharge. Seen by [second consultant] this afternoon. She refused all medication and was told that she cannot go home until she at least tries her treatment. To be seen again tomorrow'.

13. The second consultant told my officer that he saw the complainant on 29 August; she wanted to leave but because of her condition he felt she should not do so and he signed a Report on her indicating that it appeared to him that an application ought to be made for her admission to hospital under Part IV of the Act for observation or for treatment. Such a Report is made under Section 30(2) of the Mental Health Act 1959 and enables the medical practitioner in charge of the treatment of a voluntary patient to detain that patient compulsorily for a period of three days beginning with the day on which the report is made by him. He said that she was discharged on 7 September when he felt that she would not benefit from treatment at the hospital. The second consultant could find no area for criticism of the hospital's treatment of the complainant but he was perturbed to read the comment in the nursing notes for 4 September (latter part of paragraph 12). He stressed that it was not his practice to coerce patients in this way and it would be improper to do so. He remembered coming to the conclusion that the complainant was untreatable and he said that the fact that her status reverted to that of informal patient supported his view that there was no value in detaining her. He thought that a comment he may have made at the time on these lines might have been misunderstood by the student nurse who wrote the note. He did not believe there was a deliberate attempt to stop the complainant from leaving the hospital other than the legal sanction he invoked in accordance with Section 30(2) of the Act. By and large he considered that the nursing staff maintained a relaxed regime on the ward.

14. The student nurse who made the entry referring to the second consultant on 4 September (paragraph 12) was on a short period of secondment from another hospital; in evidence she stated that she was unable to recall the com-

plainant. But a sister interviewed by my officer who had been a staff nurse at the time, was not surprised to see the entry; she said informal patients were often encouraged to stay for a few days. She doubted, however, that the second consultant would have categorically told the complainant that she could not leave the hospital as it would have been out of character.

15. My officer met five members of the nursing staff who cared for the complainant while she was in the ward but none could remember her. However, the ward sister who was on duty when she was admitted, and in the week following, said she was sure that she would have remembered any unusual incident. She said that in general when an informal patient wished to leave the hospital, the usual approach was to attempt to talk her out of it; if this proved unsuccessful a doctor would be called. He would interview the patient and decide whether she should stay and ought to be formally detained, or whether she could be discharged. If a statutory order for detention was inappropriate but discharge was nevertheless contrary to medical opinion, the patient would be asked to sign a form stating she was leaving against medical advice.

16. The doctor who escorted the complainant back to the ward on 31 August was a locum Senior House Officer. His clinical notes for that day read 'called to see [complainant] who was . . . at the front reception. She said she had just been to see a solicitor in [local town] and handed me a hand-written letter which applied for discharge from the hospital. With gentle persuasion, she decided to remain in the hospital at least until tomorrow and see the ward doctor'. The letter the complainant wrote on 31 August did not seek her immediate discharge but the urgent review of her case. There is no reference in the clinical notes to the issue of a Report under Section 30(2) but I have been informed that the complainant would have been told that the Report had been made and when it ceased to have effect. The Order commenced on Tuesday 29 August 1978 and expired at midnight on Thursday 31 August. I have been told that a formal letter telling her of her reversion to informal status would, in accordance with normal practice, have been sent to her on the morning of Friday 1 September, and the AHA would expect it to have been received by her on Friday afternoon (1 September) or Saturday morning (2 September). The contemporaneous evidence – the nursing notes and the daily ward sheet – suggests that the complainant's status was considered to have reverted to that of an informal patient on 2 September – *five* days after the Report was signed.

Findings

17. The complainant has said that she asked to leave the second hospital soon after she arrived, but her recollection is not supported by the contemporaneous nursing records relating to her first four days there. On the fifth day (29 August) it is recorded that she wished to leave, but the second consultant then judged that she should remain in hospital and signed a Report under Section 30; this was a decision he took in the exercise of his clinical judgment which I may not question. Up to that point I make no criticism.

18. But Section 30 of the Mental Health Act 1959 provides that if an application for a patient's detention under Part IV of the Act has not been completed within a three-day period then the patient may not be detained any longer. The complainant's written request to leave was made on the last day of the three-day

period, 31 August, so that she would not have been able to leave immediately. However, she asked for her case to be reviewed urgently and there is clear evidence that she wished to leave the hospital on 1 and 4 September and that on the earlier of these dates she was not, apparently, regarded as an informal patient. Although there is evidence that the medical staff attempted to persuade her to remain, her action in visiting a solicitor and persistently refusing medication indicates to me a strong desire to leave. I am not satisfied that her rights as an informal patient were made known to her at the appropriate time, and since she was not discharged until 7 September, I find that she was justified in complaining that her request to be discharged was not acted on with a sense of urgency.

(c) *The unsatisfactory response by the first AHA*

19. The complainant put her complaints to the Area Medical Officer of the first AHA in November 1978; he referred the matter to the District Administrator (the DA) responsible for the first hospital. In her letter the complainant drew attention to a request from her employer for a psychiatric report following her stay at the second hospital. The DA replied briefly on 29 November that the matters she raised had been taken up by the first consultant who he understood already supplied a report to her employer. The complainant's solicitors wrote to the DA on 6 December asking for the exact reason for her transfer from the first to the second hospital. A reply was sent on 18 December explaining that the transfer was because her home address was in the catchment area of the second hospital. In June 1979 the complainant asked her Member of Parliament to take up her complaints again with the first AHA. He wrote to the DA who replied that the complainant was seen by the SHO at the first hospital and again explained the reason for the transfer. The DA added that her request in November for a psychiatric report was passed on to the first consultant as he was previously known to her. The complainant subsequently met the Sector Administrator (the SA) as she remained dissatisfied with the DA's reply; she pointed out that she did not know the first consultant at the time of her hospital admission. The SA then wrote to the Member clarifying the earlier reference to the first consultant and in October 1979 she wrote to the complainant to say the second hospital confirmed that she was referred to them by the SHO. But she remained dissatisfied and again put her complaints to the Member, who in turn referred them to me.

20. The DA told my officer that the complainant's letter of 4 November 1978 was treated as a formal complaint but it was regarded as being concerned primarily with the need for the psychiatrist's report. Her letter was discussed with the first consultant, whose clinical view was that the complainant should be sent only a brief reply. The DA said that in line with the consultant's opinion it was not thought appropriate to involve the second hospital with the complaints the complainant made about her stay there.

21. The first consultant said that he saw the complainant privately on 13 November 1978 and wrote a report which he understood was needed for an industrial tribunal hearing. Some time later he was approached by a senior administrative assistant on the DA's staff about the complaint. He said that he took full responsibility for the way the complaint was handled; he advised that a brief reply be sent because in his clinical view it would be bad for the com-

plainant to become excited over the issue. In retrospect he said the decision to be brief was, perhaps, wrong and certainly the wording of the reply could have been bettered.

Findings

22. The complainant's letter of 4 November 1978 was a reasoned presentation of serious complaints concerning two hospitals in different Area Health Authorities. The DA's investigation was largely confined to seeking the views of the first consultant, who saw the complainant once as a private patient after she sent her complaint to the first AHA. The first consultant's advice on how to deal with the complaint was a matter for his clinical judgment on which I cannot comment. I do, however, criticise the DA for his rigid interpretation of this advice, which led to a failure to reply to all the complaints directed against his own AHA, and a failure to pass on those which concerned the second AHA. The notes of the SA's subsequent meeting with the complainant lead me to believe that a serious effort was made to deal with the complaints at that stage.

Conclusions

23. I can sympathise with the complainant over what must have been a confusing and alarming experience on 25 August when she was unexpectedly transferred to the second hospital but I hope, when she has read this report, that she will accept that her admission to the second hospital was correctly arranged. While I have no reason to doubt that she then received a proper standard of care and attention at the second hospital and that the staff were well-intentioned towards her and sought to persuade her to remain at the second hospital after the period of detention had expired at midnight on 31 August, I have concluded that she was not made fully aware of her rights at that time. That was a serious omission. I have also criticised the first AHA for shortcomings in their handling of her complaint. Both AHAs have asked me to convey their apologies for these failings to the complainant through this report. This I gladly do.

Case No. W.433/79–80 – Treatment given to and discharge of elderly patient

Background and complaint

1. On 12 September 1979 the complainant's 88-year-old mother, who lived alone, was taken by ambulance to the Accident and Emergency Department (the A and E Department) of a hospital (the hospital) after falling at her home the previous evening and spending the night on the floor. She was admitted for one night (12/13 September) but was discharged the following day. She was admitted to a second hospital on 17 September when a broken femur was diagnosed. She died on 9 November. The complainant sought the help of the Member of Parliament in whose constituency the hospital was situated when she complained that:

(*a*) her mother's medical records were confused in the A and E Department with those of another patient;

(*b*) during her mother's brief stay on the medical ward she was treated roughly by nursing staff;

(*c*) she was misled over the time of her mother's impending discharge and

was not informed when a decision was made that her mother could go home;

(*d*) her mother was taken home by taxi without her door keys and she was obliged to return to the hospital;

(*e*) when she arrived at the hospital to collect her mother, she was told that a social worker wished to see them; they were delayed for two hours and then left without seeing one;

(*f*) she subsequently discovered that her mother had been discharged with a fractured femur; and

(*g*) the reply of the Area Health Authority (the AHA) to the Member about treatment was unsatisfactory.

2. I am not empowered to question decisions taken by doctors solely in consequence of the exercise of their clinical judgment and my investigation into the patient's discharge from the hospital with a fractured femur was concerned only with the possibility that an administrative fault may have contributed to the failure to diagnose and treat that fracture. Moreover, before I started the investigation the complainant assured me that she would not at any time bring proceedings in a court of law in connection with the incidents which were the subject of complaint.

Investigation

3. During the investigation I obtained the comments of the AHA and saw the relevant documents including the medical and nursing notes. My officer discussed the complaints with members of the medical, radiography, nursing and administrative staff concerned and he also met the complainant.

(a) *Confusion over the records*

4. In discussion with my officer and in correspondence, the complainant said that after receiving the news of her mother's fall, she arrived at the hospital at about 2 pm on 12 September and went to the A and E Department reception desk. She enquired about her mother and the receptionist remarked 'Oh, you mean the lady with the head injuries'. The complainant questioned the receptionist further who then picked up a folder and confirmed that her mother had a suspected fracture of the skull. A nurse intervened to say that the receptionist was looking at the wrong papers; the receptionist giggled about the confusion she had caused. The complainant said it was then discovered that the papers related to another old lady of a similar name. The incident, she said, could have been very distressing had she not known the location of her mother's injuries and pain. She could not help wondering whether the confusion over the names played any part in the failure to diagnose the fracture.

5. My officer spoke to the receptionist normally on duty at that time of day, but he saw that neither she, nor a colleague who sometimes helped her, physically resembled the person to whom the complainant spoke. The receptionist could not remember the patient or her daughter; she said that it would be quite unprofessional to refer to the patient in the manner described and it was not for her to make clinical comments about a patient. Her normal procedure was to record basic information about the patient on a casualty card; any previous medical

notes would be obtained and she would then pass these, together with the casualty card, to the nursing staff. She also entered in the A and E Department register the names of all patients attending together with the reason for seeking treatment and the action taken. The receptionist suggested that, as the complainant arrived some time after her mother, it was very unlikely that the person to whom she spoke would by then have had any more than the register to which to refer.

6. The consultant in charge of the A and E Department (the A and E consultant) told my officer that the receptionist's error would not have had any bearing on the Casualty Officer's diagnosis – there was no question of his having the wrong papers to hand and he thought the probable explanation was that a receptionist had mistakenly referred to another patient's casualty card. The Casualty Officer who first examined the complainant's mother (the CO) could remember no confusion over documents or x-rays concerning another patient; the sister in charge of the A and E Department could not remember the case but knew of no occasion when the medical notes of one patient were confused with those of another.

7. The A and E Department register for 12 September records the complainant's mother's arrival at 11.15 am and also records the arrival at 12.30 pm of another elderly patient with a similar name, aged 81, with a head injury.

Findings

8. I do not doubt that an error of reference was made at the reception desk but I do not think it was made by the regular receptionist. I have been unable to identify positively the member of staff concerned and have not been able, therefore, to establish what attitude she adopted when another member of the staff pointed out her error. Unfortunate though this error was, it was quickly corrected and I do not think the patient or her daughter was caused any hardship by it. It certainly should not have prompted any giggling but I am satisfied that the error at the reception desk was not a factor in failing to diagnose the fractured femur (see paragraph 26).

(b) *Rough nursing care*

9. The complainant said that when she saw her mother on 13 September she complained of being handled roughly by nurses when placed in a ward armchair the previous evening, and on her return to the ward following the journey to her home by taxi. Her mother said that she was treated 'as if she were a sack of coal'. The complainant took the allegation seriously because she said her mother was an independent old lady who rarely complained.

10. My officer got in touch with all day and night nurses on duty at the relevant times but only one, a day state enrolled nurse in temporary charge at the time (the SEN) could remember the case. She said that the complainant's mother was put straight to bed on arrival in the ward and following the Registrar's round the next day, was discharged. But later in the morning a hospital receptionist telephoned to say that the complainant's mother had returned to the hospital. The SEN decided that she should come back to the ward temporarily but that she was not to be formally readmitted. A porter brought her to the ward and he may have helped two student nurses to get her from the wheelchair into a ward chair. The SEN pointed out that the ward chairs were large with sloping

backs and it was not easy to transfer a patient in this way. She suggested that because of her fractured femur the complainant's mother may have experienced some pain while being moved from the wheelchair to the ward chair, and that she attributed this to rough handling, but the SEN denied that any of the nursing staff had been rough. The Senior Nursing Officer (the SNO) with responsibility for the complainant's mother's ward said that she could not accept that any of the nurses would have treated the patient roughly; and the AHA assured me that no similar complaint had ever been made against the ward concerned.

11. The nursing notes record that on admission the complainant's mother complained of backache, hip and leg pain and that pain-killing tablets were given at 5.30 pm. She complained of pain again the following morning at 7.30 am when two more tablets were given.

Findings

12. I have been unable to identify which nurses moved the complainant's mother on 12 and 13 September and only the SEN can recall her brief stay. The evidence is that she was experiencing pain and discomfort and I think that this may well have increased when she was moved particularly since the fracture had not at that time been diagnosed. It is understandable that she should attribute this to the actions of the nurses but I have found no evidence to support the contention that the patient was handled roughly.

(c) *Information about discharge*

13. The complainant said that she telephoned the hospital at 8.00 am on 13 September to enquire when her mother would be discharged. A nurse said that it was too early to say but suggested that she telephone again at 11.00 am, after the Registrar responsible for her care (the Registrar) had completed his ward round. The complainant did so and was told by a different nurse, who sounded angry, that her mother had already been discharged to her home but was now back at the hospital because no keys were found to let her in. The complainant said she knew her mother had no keys with her when she was admitted to hospital and was very surprised that she should have been discharged home without the hospital contacting her first.

14. The SEN remembered speaking to the complainant twice on the telephone. On the first occasion she told her that the time of her mother's discharge would not be known until she had been seen by the medical Registrar on his round. The SEN explained to my officer that she was very busy that morning attending one of the consultants on his ward round. She was not therefore present when the Registrar and House Officer (who worked for a different 'firm'), saw the complainant's mother and said that she could be discharged. She remembered the social work department telephoning the ward to confirm that transport was arranged and a subsequent call from reception to say that a taxi had arrived. She then asked one of the student nurses to take the complainant's mother to the taxi. The SEN said that it was her normal practice to get in touch with an elderly patient's relative before she was discharged but she could not remember whether she did so on this occasion. The SNO said that she would have expected a member of the nursing staff to have got in touch with a relative of an elderly patient before discharge. The SEN remembered the complainant telephoning on

the second occasion, after her mother's return to the ward; she could not remember the details of the conversation, although the complainant was annoyed.

Findings

15. I make no criticism of the SEN's response to the complainant's first enquiry about the time of her mother's discharge. Such a decision was a medical one and could not be anticipated by the nurse. When the Registrar made his decision, prompt action was taken to discharge the complainant's mother but no thought was given to getting in touch with the complainant who had made her interest known earlier in the day. It is a cause for concern that what is regarded as normal procedure – notifying an elderly patient's relatives before discharge – was not followed on this occasion. I uphold this complaint.

(d) *The taxi journey*

16. The complainant was distressed to learn that her mother had been needlessly taken back to her home only to be returned to the hospital because no one had checked that she had her door keys. The complainant said that they were with her husband since it was he who had gone to her mother's flat when they had first learnt of the fall.

17. The SEN thought that the responsibility for ensuring that the complainant's mother had her keys lay jointly with the nursing staff and the social work department. She vaguely remembered that she was asked where her keys were while she was on the ward and she replied that they were with a neighbour.

18. The principal social worker then in post has since left but her successor (the principal) told my officer that at the time of the complainant's mother's admission they had no social worker for the A and E Department or for the ward to which she was admitted. There was a rota system which provided cover for the A and E Department but it was late in the afternoon of 12 September when the social work department became involved. The principal did not think that they arranged transport for the complainant's mother to go home on 13 September and she did not regard it as their responsibility to look after her keys.

19. The secretary in the social word department (the secretary) told my officer that she remembered being asked by the A and E Department to arrange transport and a home help for the complainant's mother on 12 September, when it was thought that she would be discharged. She did this but the next day learnt that she had been admitted overnight instead. She could not specifically remember making any transport arrangements on 13 September but thought that she must have ordered the taxi. The keys, however, were nothing to do with her.

Findings

20. I am very surprised that no one made quite sure before the complainant's mother left the hospital that her keys were, or would be, available to allow access to her home. Responsibility for such an everyday matter should be clearly defined and the failure to do so had the effect in this case of adding to her discomfort and distress. I uphold this complaint.

(e) *The wait to see a social worker*

21. The complainant said she arrived at the hospital at mid-day on 13 September to collect her mother; a nurse told her that a social worker wished to see her mother before she left. The complainant explained that there was no need for this since she was taking her mother to stay at her home but the nurse insisted. She said that at about 1.00 pm, since no social worker had appeared a nurse telephoned the social work department. She then told the complainant that the person who wanted to speak to her was at lunch. The complainant, who had her grandchildren with her, left her mother in the ward and took them for their lunch. She returned at 2.00 pm and another telephone call was made to the social work department. The social worker was still out but the nurse was told that if the complainant was taking her mother home with her then she would not have to see the social worker.

22. The SEN said that before the complainant arrived at the hospital, she was told by someone (she could not remember who) in the social work department that a social worker wished to see the complainant. She mentioned this to the complainant and saw her leave the ward. She imagined the complainant was going to sit in the day room to wait for the social worker or that she was going to the social work department. The SEN said that it came as no surprise to receive the request since social workers often wished to see the relatives of elderly patients. She was on the ward for the rest of the mid-day period and was unaware that the complainant had not been seen, until she returned to collect her mother at about 2.00 pm. The SEN had no recollection of the telephone calls to the social work department.

23. The secretary was not aware of any contact with the ward during the mid-day period and she thought that no social worker saw the complainant's mother since any such contact would be recorded. She explained that after her lunch break she might well have been called out of the office but there was another temporary secretary who should have taken the telephone calls and if both were out they were transferred to another extension. The principal said that she had not been able to trace any member of the social work department staff who recollected conveying a message to the ward that they wanted to see the complainant.

Findings

24. The lapse of time since the patient's brief stay at the hospital has meant that memories about the events between 12.00 and 2.00 pm on 13 September have faded and I have not been able to establish exactly what happened. But the nursing notes include the entry for 12 September '. . . Social admission for 24 hrs. Seen by Social Worker, to be dealt with in the morning? discharge . . .'. As, however, it seems unlikely that the complainant's mother was actually seen by a social worker, the principal suggested that this information may have caused the nursing staff to think that the complainant and her mother were to be seen in the social work department before they left. I cannot be sure what telephone calls were made but I have no reason to doubt the complainant's recollection and I think that a failure in communication caused her and her mother to wait unnecessarily for two hours. I uphold this complaint.

(f) Discharge with a fractured femur

25. The complainant said that after collecting her mother from the hospital she took her to her own home. During the following weekend her mother was in considerable pain. She telephoned a family practitioner and he examined her mother on 17 September. He arranged for her admission to a different hospital suspecting a fractured femur and an x-ray confirmed the fracture. The complainant said she was later shown an x-ray and was distressed to see an obvious split in the bone; she wondered how a trained doctor could have missed it.

26. The CO told my officer that he remembered giving the complainant's mother a thorough examination on 12 September and noted the clinical signs of a fractured femur. He asked for a series of x-rays to be taken. He said his inexperience had resulted in his failing to notice the fracture line which was a difficult one to see. Following his examination, the CO said that he telephoned the medical team responsible to see if the complainant's mother could be admitted as a social admission. The House Officer (the HO) on this team came to the A and E Department and, he thought, also examined the x-rays without noting a fracture.

27. The A and E consultant said that the clinical notes showed that the CO had made a conscientious general examination of the patient. He omitted nothing in that examination but simply failed to spot the fracture on the x-ray. He told my officer that it frequently happened that an undiscovered fracture would widen with time, becoming more noticeable on x-rays taken some days after the injury. This explained why the complainant was able to see the fracture clearly when she herself saw the second x-ray taken five days later.

28. The consultant radiologist (the radiologist) and the superintendent radiographer explained to my officer the procedure for x-raying patients admitted through the A and E Department. The patient was first brought to the Radiology Department with a request form to have x-rays taken. These were returned to the casualty officer who was invited to examine them initially and, in the event of admission to a ward, the x-rays accompanied the patient there. They were subsequently returned to the Radiology Department in order that the radiologist might prepare a report. Reports were then returned either to the A and E Department or to the ward. The radiologist said that the complainant's mother's report should have gone to the ward; she added that while x-rays were normally reported on two or three days after being taken, the mother's report was issued quickly, the day after the x-rays were taken.

29. I have seen that the radiologist's report, issued on 13 September, stated that the complainant's mother had a fractured femur. The consultant physician, under whose care the patient was while she was on the ward, said in written evidence that the report would not have arrived on the ward until after her discharge from the hospital. It was not seen by the medical staff concerned; had they done so, the failure to diagnose the fracture could have been rectified by calling the patient back soon after her discharge. The consultant physician discovered that the radiologist's report had not been attached to the medical notes, but was, two months after the event, still awaiting filing in the medical records department.

30. The Registrar said that he remembered the CO telephoning him to ask

whether the complainant's mother could be admitted as a social admission and he agreed to this. He understood that there was nothing medically wrong with her and the decision to give her a bed for the night was simply and act of charity. Admission having been arranged, she was then examined by the HO who also saw the x-rays. The Registrar said that he began his ward round on 13 September between 9.00 and 10.00 am. The complainant's mother was in a wheelchair, dressed and ready to go: he did not examine her. Had he done so he would have asked to look at the x-rays, although these were probably then with the radiologist.

31. The radiologist's report would, he thought, have arrived on the ward the next morning – 14 September. He could not recall ever seeing it but the normal procedure was for it to be placed on a clip in the ward office with other reports waiting to be read and initialled by a ward doctor, usually the house officer. When this was done the ward clerk sent the report to the medical records office. The SEN said that the x-ray reports were either clipped on to the board as described, which was her own practice, or they might get tidied away into the patient's notes by one of the nurses who was clearing up. The SNO said she would expect a sister to read a radiologist's report and point out a reference to a fracture to the medical team.

32. The HO remembered that he as well as the CO examined the x-rays in the A and E Department prior to the complainant's mother's admission to the ward. He also confirmed that he would see all the x-ray reports and initial them. He was unable to say why this one was missed.

Findings

33. The AHA in their initial reply to the Member of Parliament said that they very much regretted the failure to diagnose the fractured femur. I am not empowered to comment on the clinical decisions of the two medical staff who saw the first x-ray of the left hip but the A and E consultant has assured me that the second x-ray, which the complainant saw, would have shown a clearer image of the fracture than did the first.

34. However, the radiologist diagnosed the fracture on 13 September and included this in her report. The report has an A and E Department stamp on it which is crossed out and the name of the ward has instead been written beside it. The probability seems therefore that the report did reach the ward but was sent for filing before a doctor had seen it. The AHA have admitted that there was a defect in the procedures for checking the reports of diagnostic tests for those patients who have been discharged from the ward before the report becomes available. In such cases such reports were passed to the medical secretary concerned for inclusion with the patient's medical notes and they have admitted that, in this case, the radiologist's report was never seen by a member of the responsible team. I strongly criticise the administrative procedures which allowed the report on the mother's x-rays to be taken from the ward without a member of the responsible medical team seeing it and acting on it, wherever the patient may have been at the time. I am therefore pleased to record that an internal memorandum was issued in December 1979 as the result of this case which requires *all* diagnostic reports to be initialled by a member of the medical staff before they are filed.

(g) *The AHA's reply*

35. On 24 September 1979 the complainant wrote to the Member of Parliament in whose constituency the hospital is situated complaining about the events of 12/13 September and he sent her letter to the AHA Chairman. The complainant saw the Chairman's reply dated 1 February but she found it casual and unsatisfactory. The Member also remained concerned and referred the case to me.

36. The Assistant District Administrator (the ADA) told my officer that the complaint was dealt with in his absence by the Hospital Sector Administrator who obtained the comments of the medical, nursing and social work staff. On 22 January 1980 the ADA wrote to the AHA enclosing a draft reply for the Chairman to consider. He recommended that it would be unwise for the AHA to refer to the faulty procedure in dealing with diagnostic reports in the circumstances that arose in this case (paragraph 34).

37. The Area Administrator (the AA) told my officer that he saw and checked the draft reply before it was passed to the Chairman. He agreed that no reference to the radiologist's report was necessary because disclosure might prompt the complainant to consider taking action in a court of law on the ground of negligence. He explained to my officer that it was not the AHA's policy to provide complainants with material which would be a basis for legal action. The AA was also satisfied with the overall tone of the reply sent to the Member.

Findings

38. I think the investigation into the complaint was thorough but there was no explanation in the reply to the complaints about the delay in seeing a member of the social work department or that the patient was roughly handled. The existence of the radiologist's report, which contradicted the findings of the CO and HO, was unknown to the Member and to the complainant and the AHA chose not to mention it. The AA has explained that it was thought that disclosure might prompt the complainant to take legal proceedings and in these circumstances it seems to me that the AHA were less than frank in sending a letter which rested solely on a denial that there was any negligence on the part of the CO in failing to diagnose the fracture.

Conclusions

39. I do not uphold the complaint that the complainant's mother was treated roughly by nursing staff. Nor do I think that there was any serious confusion over the records in the A and E Department and it certainly did not lead to the failure to diagnose the fracture; I hope the complainant will feel able to accept the assurances that the A and E consultant and other medical and nursing staff concerned gave to my officer on this point.

40. But for the rest I have found that the complainant was fully justified in pursuing her complaints. Faults in communication are at the heart of the complaints about her mother's discharge from hospital and the wait to see a social worker and the AHA have already expressed their regret for these shortcomings. The failure to diagnose the fracture gives additional importance to the radiologist's report and I have been seriously disturbed to find that no action was taken on that report. I hope that from time to time staff will be reminded of the

memorandum issued as a result of this case so that there is not a recurrence of the failure that occurred here. I have also concluded that the AHA's reply on 1 February 1980 to the complaints was less than frank; the omission of any reference to the radiologist's report meant that the procedural fault which came to light was not brought to the notice of the complainant or the Member of Parliament. I am aware that legal advice will generally discourage a health authority from volunteering information about a procedural defect if such a defect has resulted in, or contributed to, potentially actionable harm. Nevertheless non-disclosure of undeniable faults cannot be in the public interest, and while I accept that the Area Administrator in advising his Chairman in this instance was placed in a dilemma and chose to act conservatively, I think that in cases of this kind it is preferable to acknowledge openly that an error has occurred. It would be quite reasonable in this instance for the complainant and the Member of Parliament to believe that there was an attempt to cover up undeniable faults. The AHA have asked me to apologise to the complainant and the Member for all the failings I have identified in the report and this I gladly do.

Case No. W.439/79–80 – Refusal to authorise supply of breast prosthesis following operation

Background and complaint

1. The complainant's wife underwent a simple mastectomy in September 1979 at a hospital (the hospital) after having been assured that she would subsequently be supplied with a breast prosthesis on prescription through the National Health Service. The operation was carried out by a consultant surgeon (the consultant). The complainant contends through his Member of Parliament (the Member) that, following the operation, the consultant refused to authorise his wife with any type of breast prosthesis to which she was entitled under the National Health Service; and that the Area Health Authority (the AHA) thus failed to provide a service which it was their duty to provide, with the result that she was caused unnecessary distress and anxiety.

Jurisdiction

2. The Act which defines my powers specifically excludes me from investigating actions taken by doctors which, in my opinion, are taken solely in consequence of the exercise of their clinical judgment. It was not apparent from the papers sent to me with the complaint that the consultant's refusal to authorise for the complainant's wife any type of breast prosthesis approved by the Department of Health and Social Security and available from the National Health Service (which I shall term 'a standard prosthesis') was an action taken *solely* in consequence of the exercise of his clinical judgment. I therefore embarked upon enquiries into the complaint, conscious that I might at any time discover facts which placed one or more of the actions complained of outside my jurisdiction to question. I would then not have been entitled to report to the Member upon any such actions.

Enquiries

3. During the enquiries, I obtained the written comments of the AHA and I examined the relevant documents. My officers interviewed the Regional Medical Officer of the Regional Health Authority (the RMO), the Chairman, the Area

Administrator and the Area Medical Officer of the AHA and the consultant. They also examined relevant papers of the Department of Health and Social Security (the department) and spoke to one of their senior medical officers. Written evidence only was obtained from the complainant and his wife because of her ill-health. I myself also interviewed the consultant.

4. In the complainant's letter of complaint to his Member of Parliament he said that, following his wife's mastectomy, the consultant refused to authorise for her a standard prosthesis, as she had been led to expect, although he did give her the address of a firm from whom she could purchase one if she wished. The consultant said that he would supply her with a 'soft light-weight breast-form' which, the complainant said, was generally acknowledged to be only a temporary fitting to wear during the first weeks after the operation before the provision of a permanent, specially-weighted standard prosthesis. However, in January 1980, after twice being reminded about the prosthesis which he had promised to send, the consultant sent the complainant's wife an article called a 'Nature Form Beautifier'. The complainant described this as a 'dressmaker's aid used as an interlining to pre-shape garments'. He wrote to the consultant and complained that it was useless. The complainant said that the consultant had refused to authorise a standard prosthesis because it was too expensive and, also, because he believed that the difference to the patient between it and the article he had provided was 'purely psychological'. He said that, in supplying his wife with the address of a firm which could provide her with a standard prosthesis privately, the consultant had shown that he had no objection to the use of these breast prostheses on medical grounds. The complainant suggested to the Member that the availability of standard breast prostheses through the National Health Service 'should not be restricted by the obduracy of one person who is unwilling to try to understand the female make-up'. He said that the consultant had been unmoved by their entreaties and added that the grief caused by his cavalier treatment had been far more distressing to his wife than the operation itself.

5. The consultant told my officers that he recognised that the removal of a breast caused some women psychological problems. However, he said, if breast prostheses were being supplied for psychological reasons, they should be authorised by a psychiatrist and not a surgeon. He believed that his patients had no *surgical* condition which required the provision of a prosthesis through the National Health Service. He did not provide his mastectomy patients with any type of breast prosthesis until about three months after the operation when their condition could be better determined. At this stage and for cosmetic reasons only, he supplied his patients with foam cone prostheses available in three sizes which could be filled to whatever extent required by the patient. He obtained these from a chain store through the hospital supplies department and issued them himself to his patients free of charge. He considered that these washable and inexpensive articles were adequate to the patients' needs.

6. The consultant went on to say that he never authorised standard prostheses nor would he permit any members of his medical team to do so. He issued the foam cones from his own office so that his patients did not need to attend the hospital's appliance office where they might see, or be told about, the breast prostheses available through the National Health Service. He thought standard prostheses were too expensive and, he said, a survey had shown them to be

unsatisfactory because the chest wall constantly changed after a mastectomy and, as the prostheses were not adjustable, they soon became useless and were discarded. Patients took them simply because they were issued free through the National Health Service. He recalled that when he had worked at another hospital some years ago, he had never received a request for a breast prosthesis and his patients had made their own by putting cotton wool and rags in their brassières, sometimes weighting them with bird seed. It was only because the world was now commercialised 'and women wanted to go swimming' that they sought more elaborate and expensive prostheses. He considered the money could be better spent on much needed equipment for the National Health Service.

7. He told my officers that his refusal to authorise standard prostheses was *not* a matter of clinical judgment but that it sprang from a strongly held personal view that they were not essential. However, he had no objection to his mastectomy patients being referred to another consultant in order that he might authorise a standard prosthesis. His conscience was clear so long as *he* had not spent National Health Service funds unnecessarily. He said that the complainant's wife had asked him to authorise a silicone-type breast prosthesis for her. He had told her that he would *never* authorise that type of prosthesis, but he had later posted to her one of the foam cones when, in his opinion, her condition had sufficiently stabilised.

8. In an interview with my officers, the Area Administrator of the AHA (the AA) said that he had been the Group Secretary to the Hospital Management Committee prior to the reorganisation of the National Health Service in 1974 and that he had been aware, since the late 1960s, of the problem arising from the consultant's refusal to authorise standard prostheses. Following the receipt of a complaint from a mastectomy patient in 1971, he had asked the consultant to explain why he would not authorise breast prostheses and the consultant had replied that, in his view, their provision under the National Health Service was clinically unnecessary. The AA said that the AHA had been unable to take any action against the consultant because of the instructions contained in the department's handbook on the provision of medical and surgical appliances which stated that: 'It is for the consultant dealing with the patient to prescribe whatever appliance is considered necessary for the patient's condition'. As his Committee were very concerned about this situation he had written to the department in February 1971 seeking advice on how to override the instructions so that breast prostheses could be supplied to the consultant's mastectomy patients; he said that the instructions were unsatisfactory in that 'certain patients' undoubtedly underwent hardship.

9. He did not receive any substantive reply and he had reopened the correspondence in 1975 and had suggested that, exceptionally, since the difficulty had not been resolved, the Area Medical Officer (the AMO) should be given discretionary authority to allow family practitioners to authorise breast prostheses in cases where the consultant was unwilling to do so but the family practitioner was satisfied that there were no clinical contra-indications. He said that the department's reply suggested that the hospital's surgical appliance officer be authorised to supply standard prostheses to the consultant's mastectomy patients. This suggestion was not accepted as it was felt that it would be improper of the AHA to authorise a lay person to supply a patient with an appliance the

consultant thought unnecessary. It would only have been acceptable if the AMO or another doctor had been authorised to do so. The AA said that after this correspondence he had not been directly involved in the problem as he had considered it more appropriate to the AMO.

10. The AA considered that the department's instructions on the provision of surgical appliances were mandatory and he had accepted the department's view that the decision whether or not to authorise standard breast prostheses was a matter of clinical judgment. He said that the problem had been resolved in those cases where the consultant's mastectomy patients had subsequently been referred for radiotherapy because the consultant radiotherapist had agreed to authorise standard prostheses for them. In other cases, where a complaint was received, the AHA advised the patient to ask her family practitioner to refer her to another consultant for a standard prosthesis.

11. The AA said he understood that when the consultant had first refused to authorise standard prostheses his refusal had been on clinical grounds. However, he understood that the consultant had changed his ground more recently and now believed that breast prostheses should not be authorised because they were not cost-effective and because of the need to economise in the health service. The consultant was an extremely competent surgeon and his unusual view on breast prostheses was considered to be one of his idiosyncrasies. Although the AA appreciated that this was a serious matter for the women affected, he had not considered that the consultant's refusal was an action which warranted disciplinary proceedings being taken against him for professional misconduct especially if he believed he was acting in the best interests of his patients. The AA said he believed that the RMO had been aware of the problem, but he had not himself spoken to him about it.

12. The AA accepted that, in the case of the complainant's wife, the AHA had failed to provide a service they should have provided and that they must be held responsible for this failure. However, he said that as soon as the AHA became aware of the complaint, arrangements had been made for the consultant radiotherapist to authorise a standard prosthesis for her.

13. The AMO told my officers that the problem arising from the consultant's refusal to authorise standard prostheses first came to his notice in 1976. He considered that the provision of such prostheses was a matter for the consultant's clinical judgment and that, according to the department's instructions, the consultant was within his rights in refusing to authorise them. The hospital's appliance officer, with whom he had discussed the department's suggestion (paragraph 9) that standard prostheses be provided without the consultant's authority, had refused to supply them on this basis. The AMO had spoken to the consultant frequently and at great length about his refusal to authorise standard prostheses but to no avail; the consultant considered that the standard prostheses were clinically unnecessary. He had also brought the matter to the attention of the chairman of the AHA. He had sought the department's suggestions how to get round the problem; and he had requested discretionary authority for himself or for the patients' family practitioners to authorise standard prostheses in those cases where the consultant had refused to do so. However, the department had refused to amend the instructions merely because there was a problem in a single Area and could only suggest that the patients be advised to ask their family

practitioners to refer them to another consultant who *would* authorise a prosthesis.

14. The AMO said that the problem arose only rarely (he thought there had been about six complaints) because, wherever possible, the consultant performed partial, rather than simple, mastectomies thus making the provision of breast prostheses generally unnecessary. (A simple mastectomy involves the removal of all the breast tissue leaving the chest flat; a partial mastectomy involves removing only the lump in the breast plus a wedge of the surrounding tissue so that the patient is left with a small but acceptable breast.) However, he felt that, because a standard prosthesis had not been authorised for the complainant's wife, after her mastectomy, the AHA had failed to provide a service which it was their duty to provide. He believed that the department should have given him special authority to order such prostheses himself for the consultant's patients.

15. The chairman of the AHA told my officers that she had first spoken to the consultant about his refusal to authorise standard breast prostheses following the receipt of a complaint in 1975. He had told her that, in his view, they were being issued for cosmetic reasons only; they were not medically necessary and therefore a waste of public money. As a result of their discussion, she thought that he had nevertheless promised to authorise them in future but she soon realised that she was mistaken. (The AMO thought that the consultant had started to supply his patients with the foam cones purchased from the chain store at this time). The chairman of the AHA thought that it was wrong to try to solve the problem by arranging for the consultant's patients to be referred to another consultant for a standard prosthesis. She also considered that it would be wrong to advise possible mastectomy patients of the consultant's views on the provision of breast prostheses (so that they could ask to be treated by another consultant instead) because the consultant was, she said, a very good surgeon. She had spoken to the consultant several times about his refusal to authorise standard prostheses, and she believed she had done everything possible in the circumstances. The AHA themselves had no power to authorise standard prostheses without the consultant's approval and she did not therefore consider that they had failed to provide a service which it was their duty to provide. She was sure that the RMO was aware of their problem, but she did not know whether he had spoken to the consultant about it.

16. In an interview with my officers, the RMO said that he had not been aware that there had been a recurring problem over the consultant's refusal to authorise the standard prostheses. Some years ago, the department's regional liaison officer had mentioned, in passing, a complaint she had received about the consultant's refusal to authorise a breast prosthesis and had asked him if he would speak to the consultant about it. However, the matter had slipped his memory. He said that he had not seen a letter from a former Minister of State for Health to the Member (see paragraph 21) which referred to discussions he was supposed to be conducting with the consultant about the problem. He said that if the department had considered this to be something requiring his attention it should have been conveyed to him formally and he would have taken action on it. As far as he could recall, the matter had not been brought to his attention officially by either the department or the AHA. He thought that the AHA would not have been able to initiate any disciplinary action against the

consultant since the department had confirmed in their correspondence with them that his actions were within the generally recognised field of clinical judgment.

17. The RMO said that if he had dealt with the problem, he would have first spoken informally to the consultant in the hope of persuading him to change his attitude towards the authorisation of standard prostheses. If that had been unsuccessful, he 'could' have brought the matter to the attention of the Regional Health Authority, the consultant's employers, for them to take whatever action they considered appropriate. If the grounds on which the consultant refused to authorise breast prostheses were purely financial, it would have been open to the authority to tell the consultant that in this context the avoidance of public expenditure was not his concern and to instruct him to authorise the standard prostheses in future. He did not think that the AHA had failed to provide a service in this case because their actions had been restricted by the department's view that this was a matter for the consultant's clinical judgment. The RMO said he did not understand why the AHA had not first approached the RHA, rather than the department, about their difficulty since this would have been the normal channel of communication over such problems.

18. My officers have examined the relevant departmental instructions and also their and the AHA's papers on this subject. In 1966 the then Ministry of Health advised all hospitals as follows:

> 'the Department's attention has been drawn to the need to ensure the comfort and well-being of patients after mastectomy by provision of the correct type of prosthesis and additional items have therefore been included in the contract schedule. . . . The selection of the most suitable prosthesis and approval after supply by the prescribing consultant is of the utmost importance if the greatest benefit is to be achieved from the extended range.'

In 1977 the department issued a handbook – Provision of Medical and Surgical Appliances – which includes at paragraph 13:

> 'It is for the consultant dealing with the patient to prescribe whatever appliance is considered necessary for the patient's condition. A general practitioner appointed to the staff of a hospital may, at the discretion of the supervising consultant, authorise appliances on his behalf.'

The handbook also refers to 'the clinical needs of a patient' and adaptations considered clinically necessary. I understand that this wording in the handbook is similar to that in previous instructions issued by the department.

19. The records of the AHA and the department show that the Member complained to them in 1970 on behalf of a constituent about the consultant's refusal to authorise a prosthesis. The AHA told the department at that time that the consultant's view which it had obtained was that the patient concerned had no *surgical* condition which required the provision of a prosthesis under the National Health Service. The Parliamentary Under Secretary of State told the Member that 'the decision not to provide a breast prosthesis was based on the consultant's assessment of her medical needs' and went on to suggest that it was open to his constituent to ask her general practitioner to refer her to another consultant.

20. In early 1971 the AA (when he was Group Secretary to the Hospital

Management Committee) wrote to the consultant. He reminded him of the department's guidance on the provision of breast prostheses (paragraph 18) and asked for a report for the Committee who, he said, could not understand his reluctance to authorise a prosthesis in this case. The consultant replied:

> '. . . I have so far not found it necessary to prescribe under the National Health Service such a prosthesis as I believe that the normal brassière, stuffed with some soft material, is a much better form of prosthesis than the artificial one and this ensures the comfort and well-being of the patient after mastectomy. As the condition in this patient's breast was a simple, non-malignant lesion, I was unable to satisfy myself that on medical grounds there was any necessity to prescribe a surgical appliance under the Health Service.
>
> I am sure the Management Committee and the Ministry will understand that I have no hesitation in ordering a special appliance when it is for the well-being of the patient, but I am very reluctant to do so when this is not the case.'

21. In October 1975 the Member complained again to the department on behalf of his constituents. It was decided that the RMO should be asked to discuss the problem with the consultant to see if he could resolve the situation. The department's records show that the request was made to the RMO on two occasions. In a letter of 9 April 1976 to the Member the Minister of State said:

> '. . . In my letter of 20 January I indicated that I expected that local discussions between the Regional Medical Officer and the surgeon concerned might resolve the situation. Unfortunately it has not yet been possible for the RMO to arrange these. Other ways around the situation have also been explored but I am afraid in the end to no avail. You will appreciate that it is not possible to instruct a consultant in a matter which relates to the exercise of his clinical judgment and the only advice I can offer is that the patients could ask their general practitioners to refer them to other surgeons. This is a most unhappy situation for the women concerned and I will ensure that my officials keep the issue before the Regional Health Authority.'

A copy of this letter was sent to the AHA and it was also proposed that a copy should be sent to the RMO, but there is no record that this was done.

22. From 1977 to 1979 the AHA pressed the department for a solution to their problem; the department considered it and also put it to one of their independent consultant advisers. The correspondence ended in April 1979 with a letter from the department to the chairman of the AHA which said *inter alia* –

> 'Much as we regret that surgeon's attitude we have no option but to accept that his refusal to prescribe is a clinical decision with which neither this Department nor Dr——, as Area Medical Officer, can interfere.'

23. In November 1979 the Honorary Secretary of the Mastectomy Association (the Secretary) asked the department for their help in persuading the consultant to provide the complainant's wife with a standard prosthesis; the department replied that they could not interfere with a clinical decision.

24. In a further letter in February 1980 the Secretary advised the department that the consultant had given the complainant's wife the address of a supplier

from whom she could obtain a breast prosthesis privately. She said that some patients were 'permitted' to see the hospital appliance fitter and purchase standard prostheses privately but that patients of other surgeons had their prostheses ordered under the National Health Service. She also enclosed a letter which the consultant had written to the complainant in February 1980 which said:

> 'Thank you for your letter about [Mrs ——] following the recent removal of her left breast. I do understand the trauma that such an operation does inflict and I in no way underestimate this.
>
> As you probably know, patients after this type of operation need a great deal of care and follow-up and may require expensive drugs and apparatus if recurrence takes place. As a result I believe I must get my priorities right and naturally I feel that the provision of facilities for active treatment is more important. I hope you will understand my reluctance at certain stages to order a breast prosthesis. My main aim is to see that [Mrs ——] remains well from the point of view of her breast trouble.
>
> I do understand this aspect of the female make-up but I have a great belief in the fact that most of our patients have the capability to accept their disfigurement and all seem to have the ability to invent a suitable substitute which worked in the past but for some unknown reason replacement by a manufactured artificial breast has become fashionable, but of whatever type it never replaces the natural breast. Even the plastic surgeons are unable to provide a substitute.'

25. In March 1980, shortly after the Member referred this complaint to me, the Secretary wrote to the Minister of State for Health seeking his help. The Deputy Chief Medical Officer at the department wrote to the consultant and asked him if he would reconsider his attitude and whether he felt he could adopt the general principle followed by nearly all his colleagues of authorising a prosthesis if it was requested and there were no clinical contra-indications. The consultant replied that there must have been some misunderstanding as he had been authorising prostheses for at least two years and had sent the complainant's wife an 'artificial bra' on 24 January. He was then asked whether the article he had provided was in fact a 'Nature Form Beautifier' – a device worn with certain garments to improve the shape of natural breasts, and not a prosthesis suitable for a patient who had lost a breast. He replied that this was correct and that it was a 'device which I have found most satisfactory as a substitute for an absent breast'. The department considered that, as in the consultant's judgment the article he had provided was satisfactory, they could not take the matter further and the Secretary was advised in July by the Minister that the consultant was entitled to make his own clinical judgment on the matter and that neither he nor anyone else could overrule it.

26. My officer interviewed a senior medical officer at the department who said that they should defend a consultant's right to authorise what he thought was of benefit to his patient. They had, he said, believed that the consultant's refusal to authorise a standard prosthesis had been founded on clinical grounds and therefore there was little they could do other than to endeavour to find a way round the problem such as by suggesting that family practitioners should refer their patients to another consultant for the authorisation of a standard breast prosthesis when the consultant had completed his treatment. The senior medical

officer said that he thought that the RMO had been asked on several occasions if he would speak to the consultant about the problem.

27. In the light of the evidence I received, which is recorded in preceding paragraphs, I decided that I ought to give the consultant an opportunity of being heard by me personally. I invited him to bring with him a friend or representative of his professional indemnity society if he so wished. In the event he came alone on 6 May 1981. In addressing me, he accepted that for many years past he had refused to authorise any prostheses on the ground that they were unnecessarily expensive devices, heavily promoted by the manufacturers and for which the National Service should not pay. But in making his submissions to me, he introduced for the first time in my enquiries into this case a suggestion that there was a clinical reason for not authorising the standard prosthesis which the complainant's wife wanted, namely that the silicone material of which it was made was non-absorbent and therefore liable to cause a sweat-rash or chafing on any irregularity in the skin such as scar-tissue. I regret to say that I found wholly unconvincing this belated attempt to assign a clinical ground for denying the complainant's wife a prosthesis from National Health Service resources, which he was quite willing for her to have if she paid for it herself. Never in all the correspondence between the consultant, the Area Health Authority, the complainant and his wife, the department and myself did the consultant raise the idea that there might be a clinical objection to authorising the standard prosthesis. When I asked him why this important reason, if valid, had not been mentioned either to the complainant or to the AHA, the consultant said that he felt it was 'incomprehensible' and must have been the result of 'a mental block'. I regret to say that I do not accept as a fact that this clinical reason, which in the light of the widespread use of a standard prosthesis for mastectomy patients is in any event unconvincing, ever operated on the consultant's mind when he refused to authorise the device for the complainant's wife. And the observations of the consultant which I have quoted in paragraphs 20 and 24 and which I found very obscure, do nothing to modify that view.

28. The consultant wrote to me on the day following his attendance before me and said: '. . . I got out my notes and on 10.11.79 I interviewed Mrs. —— myself and explained to her why she was refused a silicone bra. The substance of this interview can be confirmed by my senior resident who is still employed by the hospital authority. . . '. I therefore re-examined the clinical notes and I find nothing in them to corroborate this new recollection on the part of the consultant. Moreover, I had drawn his attention to the entry in the complainant's wife's notes for 10 November 1979 in the course of his attendance before me and no such recollection then occurred to him. I caused enquiry to be made of the doctor referred to by the consultant as 'my senior resident', in fact the surgical registrar. This doctor told one of my officers that he recalled the consultant mentioning, at the interview on 10 November 1979, that the standard prosthesis might cause chafing. I am no more persuaded by this recollection, uncorroborated as it is by any previous record or assertion, than I was by that of the consultant.

29. It is entirely right and necessary that a consultant, when prescribing, treating or authorising appliances for patients, should take into account the cost thereof. He may sometimes determine on clinical grounds that no appliance is

necessary or that none could be useful. And where a consultant has a number of options at his disposal, he will naturally choose that which combines economy with the interests of the patient in which he judges to be the proper proportions. Whether in doing so he exercises a judgment which is solely clinical or partly clinical and partly administrative is a question I need not decide for the purpose of this complaint. I would be inclined to think that it is a judgment in which clinical and administrative functions are combined, as plainly envisaged by the National Health Service Act 1977, Schedule 13 paragraph 19. However that may be, where, as I here find, a consultant refuses to authorise an appliance at all on the sole ground of cost, it is impossible in my opinion to say that his action or inaction is taken solely in consequence of the exercise of his clinical judgment. I am therefore of the opinion that the consultant's refusal to authorise a standard prosthesis in this case was not an action taken solely in consequence of the exercise of his clinical judgment. It follows that this part of the complaint lies within my jurisdiction and I accordingly make this report on it.

Findings and conclusion

30. Officers of the AHA have expressed the view to my officers that they failed to provide a service which it was their duty to provide. This admission is not, of course, conclusive, but in the light of the evidence I agree with it. I think the consultant's failure to provide the complainant's wife with a standard prosthesis was a failure in the service and his refusal to authorise such a prosthesis for her in all the circumstances was obdurate and indefensible. That refusal caused her to suffer considerable distress and anxiety. I therefore uphold the complaint. I have also criticised the AHA who have asked me to convey their apology to the complainant and his wife and this I gladly do.

31. Before parting with this case, I ought to say that it is unique in the experience of my Office. It is therefore in no way representative of attitudes in the service generally. I think it is possible that the attitude of the consultant concerned, soon to retire from the service, was rooted in standards long since outdated. I do not expect such a case ever to recur.

Case No. W.7/80–81 – Restrictive hospital visiting hours for children

Background and complaint

1. A wife was admitted to hospital (the hospital) on 7 January 1980 for a hysterectomy. Before her admission she learned from a leaflet enclosed with her letter of admission that the only time when children under the age of 12 would be allowed to visit the hospital was on Sundays. The complainants, who have two children who were aged five and three at the time, regarded this as unduly restrictive. On 22 December 1979, therefore, they attended a meeting with the sister on the ward to which the wife was to be admitted (sister A) and a nursing officer (the NO). The outcome of this meeting was that the complainants were refused their request for a relaxation of the rule.

2. They complain through their Member of Parliament that:

(*a*) the visiting hours for children are too restrictive;

(*b*) the NO was insensitive and impolite at the meeting on 22 December 1979; and

(*c*) they are dissatisfied because the district administrator (the DA) of the Health District of the Area Health Authority (Teaching) (the AHA) who dealt with their complaint did not arrange an impartial investigation.

Investigation

3. During my investigation I obtained the comments of the AHA and examined these and other relevant papers. One of my officers interviewed the nursing, medical and administrative staff concerned and another of my officers met the complainants. The Secretary of a Community Health Council (the CHC) who had helped the complainants pursue their complaint was not available for interview because of long-term illness and the district nursing officer (the DNO) who has retired for health reasons was not interviewed.

(a) *The complaint about visiting hours*

4. The complainant told my officer that she had a great affection for the hospital; not only had she worked there for some two years as a social worker, but she had also stayed there on several occasions for obstetric treatment and had always been treated well.

5. However, she said, when she received a letter notifying her of the date of her admission, she was surprised to learn from a leaflet enclosed with it that visiting by children under 12 was restricted to Sunday afternoons. The leaflet (a copy of which I have seen) also carried a suggestion that parents should: 'Talk to Sister or the Nurse in charge about it'. Because the complainants were unhappy that their children's visits were to be so restricted the husband telephoned the ward and spoke to sister A. He told my officer that she was very pleasant but told him that arrangements for children's visits could not be changed. However, if his wife was well enough she could see her children in the corridor. She added that as she was to be admitted on a Wednesday it would not be long to wait until the Saturday. (In fact she was admitted on Monday and had the operation on the Wednesday.)

6. The complainants told my officer that they believed that the other two large local hospitals were less restrictive in their visiting hours for children and added that their children needed to see their mother only very briefly to be reassured that she 'was not dead'. They therefore approached the CHC who made arrangements for them to visit the hospital on 22 December 1979 for a meeting with sister A and the NO who said that the rule could not be changed.

7. Having obtained no satisfaction from the meeting with sister A and the NO the wife wrote to the consultant gynaecologist (the consultant) on 29 December saying '. . . I am very concerned about the effect of the separation on my children who are already showing anxiety symptoms connected with my admission'. She went on to explain the result of her meeting with the nursing staff and asked the consultant whether he could arrange for her to see her children on the Friday and Saturday whether or not she was fit to leave the ward. However, the letter was delayed in reaching the consultant and he did not reply to it until 16 January (the day after she was discharged) when he apologised for not previously being aware of the nature of her concern. (She told my officer that she did, in fact, see her children on the Friday, but in a draughty corridor.)

8. The consultant told my officer that had he received the letter earlier he would probably have passed it to the nursing staff as he considered it their responsibility to apply hospital policy regarding visiting hours and it was not for him to interfere. He explained that because of the number and type of cases dealt with (including major operations and prostaglandin abortions) his own view was that the ward was not a suitable place for children on weekdays when there was heavy traffic between the theatre and the ward and therefore thought the visiting rule was right provided it was not applied inflexibly. He could envisage exceptional circumstances when children under 12 should be allowed to visit the ward; he also thought that the nursing staff were not entirely reasonable in their insistence that the day room should not be used for visitors. He felt, however, that the wife had been selfish in refusing to accept that the presence of children on the ward could be upsetting to other patients or that the ward was not in any case a suitable place for children. He went on to explain how busy the ward was and, in fact, the health district's statistics shows that in 1979 over 2,000 patients passed through the 28-bedded ward.

9. One of my officers visited the ward and saw that the 28 available beds were arranged in screened bays of four and two with at the door end of the ward a waiting area for visitors which was only partially partitioned off from the main ward. Passing traffic in and out would be visible to this area and any noise from the ward would be quite audible and therefore would not offer a secluded area where children could see their parents.

10. During his visit to the ward my officer spoke to the sister on duty (sister B). She confirmed that children who visited their mothers outside official children's visiting hours would normally have to be seen outside the ward. However, in special circumstances exceptions were made. But it would depend on what was happening on the ward at the time and would be for only a very brief visit. She told my officer that she did not find that the restricted visiting times presented any great problem. Most patients were happy to accept them. There is a small interview room off the corridor outside the ward but this is not always available as it is used by staff interviewing patients. The patients' day room is off the same corridor but sister B said she would not be happy for that to be used for child visitors. The patients' day room was a 'precious sanctuary' where ambulant patients could relax away from the activity of the ward and she thought it should be kept for that purpose.

11. A senior nursing officer who was also on the ward during my officer's visit supported the views expressed by sister B and particularly emphasised the need for the patients' day room to be kept solely for that purpose. He added that he was not happy with the waiting space available or facilities for visitors generally; but the layout of the hospital precluded any possibility of improvement.

12. Soon after her discharge from the hospital the wife, in a written statement to the CHC, set out details of her experiences and explained her reasons for objecting to the visiting rules. The statement was tabled at a meeting of the CHC on 21 January 1980 at which she spoke; and the CHC agreed to give further consideration to this matter in conjunction with the District Management Team (the DMT).

13. On 29 January the CHC Secretary wrote to the DA and told him of the CHC discussions and asked for 'a favourable response' on the matter, pointing

out that no similar *general* restrictions existed in similar wards in other local hospitals although in these hospitals the sister in charge of the ward had authority to restrict children's visiting if it were necessary.

14. On 6 February the DA replied to the CHC Secretary that the matter had been discussed with the consultant gynaecologists and the view was still that 'the present arrangements are the best that can be provided given the physical geography and the workload of the particular ward in question'. And I have seen a minute of a meeting of a Division of Obstetrics and Gynaecology held on 28 January which records the resolution 'that the DMT be advised that in the opinion of the Clinicians the visiting arrangements for "L" ward are satisfactory and in the interests of the patients in general, should not be changed'.

15. On 24 February the CHC Secretary wrote to the complainants and told them the contents of the DA's reply. He also told them that when the CHC discussed the reply at their meeting of 6 February several members who had visited the ward since the meeting of 21 January stated that all those patients they had interviewed were satisfied with the present arrangements and some had indeed stressed that they preferred their young children not to visit them until such time as they were fit to see them. In the circumstances, the CHC had concluded that 'in general, visiting arrangements to the wards at —— hospital had not been the subject of undue criticism and decided to take no further action in respect to any proposed change in the current visiting rules'.

Findings

16. I have no doubt that the wife was genuinely concerned that separation from her might adversely affect her children. In the event, she was well enough to go and see them, two days after her operation (as she had requested in her letter to the consultant), albeit in uncomfortable conditions. The professional staff take the view that the restriction on children's visiting is generally in the best interests of the patients. I do not consider there was any maladministration in reaching that opinion and I do not therefore uphold this aspect of the complaint. But I think the AHA should consider whether there is any way in which they can improve the arrangements for mothers to see their children *outside* the ward.

(*b*) *The complaint about the meeting on 22 December 1979*

17. On 1 February 1980 the husband wrote to the DA and complained about the NO's behaviour and attitude to his wife and himself at this meeting. The interview with sister A had been arranged by the CHC Secretary to discuss the possibility of their children visiting their mother during her admission at times other than the official visiting hours on Sundays only. At this interview, the husband alleged, the NO addressed him in an insulting and offensive manner and implied that he and his wife had no right to question the hospital rule on visiting hours or to ask that it be flexibly operated; when asked, she denied knowledge of the 'whereabouts' of the DMT; and when it was put to her that other hospitals allowed daily access of children to their parents she asked 'why the wife had not gone to one of these other hospitals', she also said that 'if they could not afford a pay bed they must put up with what the National Health Service provides' and that the hospital would be 'glad to see the back of' the wife. The husband said

that his wife had been so distressed by this interview that, after her operation, she had sought an early discharge from the hospital, having in the meantime seen her children in a draughty corridor at the cost of personal discomfort.

18. The DA acknowledged receipt of the husband's letter on 6 February and, after asking the DNO and the consultant for their comments, replied to the husband on 12 February. He said that sister A did not feel that the NO had been in any way insulting or offensive nor had she implied that patients or their relatives had no right to question any rules or to ask for them to be operated flexibly. He said, however, that the NO agreed she did not know the full composition of the DMT or the frequency and venue of their meetings and was not aware of visiting practices at other hospitals; and he felt that the NO had implied that if the wife was not using a pay bed she must accept what was provided by the National Health Service. He also said that after the DNO's enquiries she was convinced that the NO had not said that she would be glad to see the back of the wife but, he understood, the words had been used by the wife herself and both sister A and the NO had replied: 'certainly not'.

19. In a written statement to me the NO denied that in the interview with the complainant she had implied that the wife had no right to question hospital rules; but she said that she had indicated that the final decision on hospital policy must rest with the DMT and hospital staff. She admitted to not knowing the full composition of the DMT or the frequency or venue of meetings but said she had told the complainants where they could obtain the information. She admitted, too, that she was not aware of visiting rules at other hospitals in the area. She said that sister A had explained that the wife would be unable to see her children only on the day of operation and the next day. After that she would be ambulant and well able to see her children in the corridor. It was explained that weekday visiting was unsuitable for children as the ward was always busy with an average of six admissions in any afternoon and as many as 14 patients going to and from the operating theatre in one day. She and sister A therefore felt it was wrong to make an exception to the hospital policy and unfair to other mothers in the ward. Therefore the NO suggested that the wife either had her operation in another hospital in the city, left her children with relatives or friends during visiting hours or, failing that, had the operation done privately. She said that the complainants could not accept any of these alternatives and continued to press their point that other hospitals in the Region had open visiting and that the hospital should follow suit. The NO denied that she had said that she would be 'glad to see the back of Mrs ——' adding that in fact it was the wife herself who said 'you will be glad to see the back of me' and she had replied 'certainly not'.

20. The NO strongly denied to my officer that she had been rude to the wife. She said that when she joined the complainants and sister A there was nothing unusual about the wife's attitude but that as the interview went on she became more and more agitated. It became clear that she was not seeking preferential treatment for herself and her children but was challenging the general principle of the restrictions on visits by children under twelve. The NO explained to my officer how busy the ward was and said that, after major operations, patients were not usually in a fit state to see their children on the day of operation or on the day after. In exceptional circumstances the visiting rule could be relaxed to

allow young children to see their mother on the ward inside normal visiting hours for adults and over-twelves; she had told the complainants that if she were not able to get out of bed to see her children within a few days the circumstances would have been considered and the children would probably be allowed to see her very briefly in the ward. However, at the interview on 22 December the wife was arguing a point of principle and the NO had simply explained the hospital's policy which it was not within her powers to change. She was aware that the wife was not satisfied with the result of the interview but she was in no doubt that she had dealt with her representations calmly and had not at any time acted unprofessionally.

21. Sister A told my officer that she first heard from the husband when he telephoned her some time before Christmas 1979 to ask about visiting times, and she had told him that the arrangements for children visiting the ward were as notified and could not be changed. Some time later the CHC Secretary had arranged for the complainant to come to the ward for an interview with her. On the day of the interview she had been very busy and had been late for her appointment with them, but she had immediately apologised for this. The wife, she said, looked very aggressive and was 'uptight', but her husband appeared calm. Sister A gathered that she wanted her children to visit her on the ward outside the normal children's visiting hours and she explained that the general rule could not be changed.

22. Sister A said that the NO had explained the reasons for the hospital policy on visiting hours and said that the rules could not be changed. However, compromises could be made in certain circumstances. It was not always possible to know exactly when a patient would be fit to see her children after a major operation but usually a patient who had an operation on Wednesday would be ambulant on Friday and would be able to see her children outside the ward. Initially this seemed to be accepted and the husband had said to his wife 'Happy? I think that's quite good, don't you?' But she did not seem to be able to appreciate the feelings of other patients and adopted, she thought, a 'selfish attitude' to the general rule. Sister A could not remember, beyond that, the course of the interview, but in her view the NO had been firm but not rude and had certainly not said that they would be 'glad to see the back of Mrs ——'.

Findings

23. It is always difficult, some time after the event, to establish the tone of a discussion. But the NO and sister A have said in separate interviews that the NO was firm but not rude and, specifically, that she did not make the alleged remark. On the evidence, I do not doubt that there was a strained atmosphere and I believe that this was because the wife was seeking to persuade the NO that the general rule about children's visiting was misconceived and should be altered and was not prepared to accept that, as I think she was told, a brief visit would probably be allowed if her recovery from the operation was delayed. And from her letter to the consultant (paragraph 7) this was all she really wanted. I consider that this whole affair was very unfortunate but I am not convinced that the nursing staff concerned were to blame and I do not find that the complaint is made out.

(c) *The complaint about the response by the DA*

24. In a letter of 25 March 1980 to their Member of Parliament the complainants said they wished to complain about the unsatisfactory nature of the investigation of the complaint they had made to the DA in that he did not 'appoint an impartial investigator into the formal complaint'.

25. The DA explained to my officer that when he received the husband's formal complaint of 1 February 1980 he considered it to be a purely nursing matter and therefore based his reply of 12 February 1980 on the comments he had received from the DNO (who was head of the local nursing service and a member of the DMT) after she had interviewed both the NO and sister A.

26. When the husband replied on 26 February 1980 he said he was not satisfied and intended to pursue the matter further; the DA therefore thought his acknowledgement of the letter which he made on 4 March was sufficient response.

Findings

27. The complainants took the view, which they expressed in their letter to the Member, that the DNO was not an impartial investigator and that the failure to appoint such a person constituted maladministration. I profoundly disagree. It would be manifestly absurd for any health authority to expend limited National Health Service resources in mounting an independent enquiry into any but serious and far-reaching complaints. I do not consider that this complaint is of that nature and I find no evidence of partiality on the part of the AHA. I dismiss this aspect of the complaint.

Conclusions

28. I have reported my findings in paragraphs 16, 23 and 27 of my report. I understand the complainant's concern that their children should not be prevented from seeing their mother as soon as was practicable, but I do not uphold their complaints.

Case No. W.11/80–81 – Psychiatric hospital admission and patient's rights

Background and complaint

1. On 23 June 1979, following events that stemmed from an argument with her husband, the complainant was taken at 10.30 pm by police officers from the home of a friend to a hospital (the hospital). She was detained there for three days pursuant to Section 29 of the Mental Health Act 1959 (the Act), on an emergency application for admission for observation made by a social worker and supported by a medical recommendation of a family practitioner (the FP). After the statutory Order expired, the complainant remained at the hospital as a voluntary patient until 6 July and from 9 July to 17 September she was treated at the Day Unit. She complained that:

(*a*) before accepting her as a patient, the hospital should have investigated the circumstances of her admission under the statutory Order;

(*b*) on admission she was refused permission to telephone her father or to see a psychiatric nurse who was her neighbour;

(*c*) she was not told immediately of her rights or the legal basis under which she was detained;

(*d*) although she was told by medical and nursing staff on the night she was admitted that they believed her sane, they took no action to ensure that she was quickly discharged;

(*e*) when her father telephoned the hospital on 25 June and asked if he might visit, he was told there was little point in coming;

(*f*) after the statutory Order expired she was advised by a nurse that it would be in her own interest to remain as a voluntary patient since she was likely otherwise to be 'Sectioned' for a further 25 days; and

(*g*) she was dissatisfied with the replies of the Area Health Authority (the AHA) to her complaints.

Jurisdiction

2. When the National Association for Mental Health (MIND) first wrote to me on behalf of the complainant the complaint included aspects which were directed against the social worker and the FP involved in the application for her admission. The social worker was employed by the County Council and her actions were therefore subject to investigation by a Commission for Local Administration. That investigation has been completed and a separate report of the results will issue concurrently with this one.

3. As to the FP, I am precluded by Section 116(2)(b) of the National Health Service Act 1977 from investigating any action taken in connection with general medical services by a person providing the services. I have considered whether the FP, when he completed a form of recommendation for the detention of the complainant under Section 29 of the Act, was providing general medical services for her. In particular I have considered whether the fact that he may have been entitled to a fee from the relevant local or health authority in respect of all or part of what he had to do in order to arrange compulsory admission to a mental hospital, makes any difference to his status. I have come to the conclusion that it does not. There are many items of service which FPs render to their patients for which they receive a National Health Service fee. Nor do I see any difference in substance between the duty to take steps necessary to secure for a patient emergency admission to hospital for physical illness and the duty to do so for mental illness, notwithstanding the element of compulsion in the latter which is absent from the former. The complainant was at all material times the FP's patient for the purposes of the National Health Service Act, 1977 (the FP being the partner of the FP on whose list the complainant was) and I hold the completion of the recommendation under Section 29 of the Mental Health Act, 1959 to have been a provision of general medical services. Accordingly the actions of the FP are in my judgment outside my jurisdiction and I have not investigated them. The position may be otherwise where an FP is called upon in an emergency to examine and recommend the detention in a mental hospital of someone who is not his patient, to whom he owes no duty to provide general medical services and where the request for the service comes from a health or other proper authority.

Investigation

4. During the investigation I obtained the comments of the AHA, saw their correspondence with the complainant and MIND and examined the medical and nursing notes. One of my officers discussed the complaint with members of the medical, nursing and administrative staff. He also met the complainant, her husband, her father and one of her neighbours.

(a) *Admission to the hospital*

5. In discussion with my officer and in correspondence the complainant said that on the day she was admitted to the hospital she had a fierce argument with her husband and sought comfort at the home of a neighbour. It was there, at about 10.30 pm, that a police constable and two other policemen called and despite her protest that she had not seen a doctor they insisted that she accompany them to the hospital. After waiting in the hospital corridor for some twenty minutes, the complainant said a social worker arrived and informed her that she was to be admitted to the hospital because she was drunk, had been violent and had made threatening remarks. The complainant was very angry at what she considered to be unjust allegations. She said that she saw a male nurse, in fact a Nursing Officer (the first NO), and a doctor and she recalled that she told them that she did not think it right that she should have to go into hospital without first seeing a doctor. A few days later she repeated this to the consultant psychiatrist (the consultant).

6. The consultant told my officer that he had met the complainant a few days before her admission. He had thought she was a very distressed lady and I have seen the letter he sent to her family practitioner after the consultation. The consultant said that the hospital staff were not obliged to accept her as a patient on 23 June but he thought that they were right to do so given the serious concern expressed by the social worker and supported by the FP. But, in his opinion, the complainant was in a neurotic state at the time and he himself doubted the wisdom of treating neurotics compulsorily. He told my officer that this was why he had later written to the Area Administrator that he was surprised and concerned when the complainant had been committed to the ward under Section 29 of the Act.

7. The consultant said he was aware that the complainant had complained to his staff about the fact that she was being detained, but it was not until after she left the hospital, when he saw copies of correspondence concerning her complaint, that he realised one of her complaints was that she was not examined by the doctor who signed the Section 29 Order, prior to her being taken to the hospital.

8. The Senior House Officer (the SHO) who admitted the complainant told my officer that the patient had not said that she had not been seen by a doctor prior to coming to the hospital. The SHO recalled that during their conversation the complainant concentrated on the misdeeds of her husband rather than complaining about the way she had been brought to the hospital and that the complainant accepted the SHO's suggestion that it was reasonable to allow the situation at home to cool and that it would be better to make use of the bed at the hospital.

9. The first NO has told me that the complainant in her conversation with him never mentioned that she had not been seen by the family practitioner. He recalled that she asked to see a solicitor but the first NO said he would like her to see a doctor and she agreed to go to the ward where she was examined by the SHO.

10. I have seen that on the relevant form giving the medical recommendation supporting the social worker's application the FP indicated that he had examined the complainant on 23 June. As I have explained, his actions are not within my jurisdiction (paragraph 3). But in the course of the correspondence I have seen that MIND suggested that the complainant's admission under Section 29 of the Act was unlawful because she had not been 'personally examined' by the doctor making the medical recommendation. They also suggested that the hospital managers did not have a valid authority for detaining her. The Unit Administrator was concerned at this latter criticism and made the point in internal correspondence that without prior knowledge of the circumstances at admission the managers could only consider documents at face value and that there was no obligation placed on them to check the validity of the evidence given. He suggested that Section 31(3) of the Act made this clear. This provides:

> 'Any application for the admission of a patient under this Part of this Act which appears to be duly made and to be founded on the necessary medical recommendations may be acted upon without further proof of the signature or qualification of the person by whom the application or any such medical recommendation, is made or given, or of any matter of fact or opinion stated therein.'

Findings

11. I think that the hospital staff were reasonably entitled to accept at face value the signed certificate which indicated that the FP had examined the complainant on 23 June. The statute specifically provides that the hospital managers may act on the application without further proof of any 'matter of fact or opinion' stated in the certificate. I do not think that it is administratively practicable to do otherwise. However, I have considered the complainant's allegation that she told 'everyone' that she had not been seen by the FP that day. The NO who first saw her, the SHO who admitted her and the consultant who saw her two days later all said that they could not remember her saying this. In these circumstances I do not find that the hospital managers acted incorrectly in detaining her or that they should have enquired further into the events of that day before admitting her.

(b) *Refusal to allow approaches to father and friend*

12. The complainant said that at about 11.15 pm on the evening of her admission she begged to be allowed to telephone her father but was told that it was too late at night. She also asked to be allowed to see a neighbour who worked as a night nurse at the hospital and who was on duty that night. This too was refused.

13. The first NO recalled that he visited the complainant's ward at about 12.30 am; a State Enrolled Nurse (the SEN) told him that the complainant had wished to make a number of telephone calls. He spoke to her and found that

she wanted to get in touch with her father who lived at a distance. It was late and he noted that she was still very excited so he suggested it might be better if she waited until the morning before making the call; she agreed without further dissent.

14. The first NO did not know that the complainant had asked to see her nurse neighbour. Had he known, he would have first put her request to the nurse concerned and given him the opportunity to decide whether he wished to see the complainant. The SEN told my officer that she recalled the complainant wanting to make some telephone calls, one of which was to a nurse. As it was so late she advised against it. Both the consultant and the Divisional Nursing Officer (the Div NO) expressed the view to my officer that while the hospital encouraged patients to use the telephone, in the circumstances it was reasonable for the complainant to be encouraged to defer her telephone calls until the morning. They both recognised that the situation was highly charged that night and it needed to be defused.

15. A student nurse recalled that she accompanied the complainant to the telephone the following morning, 24 June, to make a call to her father. The complainant's father told my officer that he remembered that his daughter telephoned him that morning and explained where she was and her predicament.

Findings

16. The complainant's father told my officer that she turned to him when in need of help and I can well understand why she tried to do so on the night of 23 June. Understandably, too, she attempted to see a member of the staff who was known to her. But in the professional judgment of the nursing staff it was advisable for her to wait until the morning. I do not question that judgment and am satisfied that she accepted the advice without further ado. In any event she spoke to her father the following morning and I do not think that she suffered any significant hardship as the result of the decision to defer her call.

(c) *Advice about rights*

17. The complainant said that on admission she was not told of her rights or the legal basis for her admission and it was not until the next day that she learned from a student nurse under which Section of which Act she was being detained and for how long.

18. The first NO said that during the talk he had with the complainant the first night the legal basis for her detention arose. He explained that her admission was under Section 29 of the Mental Health Act 1959 and was for a maximum of 72 hours. The student nurse who was on duty on the morning of 24 June recalled the conversation with the complainant about the Mental Health Act and lent her a pamphlet called 'A Glossary of Psychiatric Terms' which included reference to, and the effect of, the relevant Sections of the Mental Health Act. The sister in whom the complainant had confidence said that she was on day duty on 25 June and that she certainly knew her rights then.

Findings

19. I am faced with a conflict of evidence on this aspect of the complaint. The first NO has told me that he did explain the legal basis for her admission but it has not been possible to establish just how fully this was explained to the patient. The complainant had experienced an unhappy series of incidents during the day and I do not doubt that she was in a highly emotional frame of mind that night. In the circumstances I think it is possible that she did not take in any explanation given to her soon after she was admitted. Such circumstances seem to me likely to occur frequently when compulsory detention has been thought to be appropriate and I am therefore pleased to record that as from the beginning of the year patients are handed a written document on arrival explaining the legal basis of their detention.

(d) *Failure to discharge the complainant quickly*

20. The complainant said that when she was unable to go to sleep straightaway on her first night she talked to two night nurses. They told her that the SHO on duty who had examined her believed her to be sane and that they, the nurses, agreed. She said that in that respect she found it hard to understand why, if the nurses and doctor thought her sane, she was not quickly discharged.

21. I have seen the medical notes that the SHO made after her initial discussion with, and examination of, the complainant. The SHO came to the conclusion that the admission was mainly a social one and to alleviate the situation at home. The SHO told my officer that she was not sufficiently experienced to judge whether admission under Section 29 was the right approach and it would have been for the consultant to have set aside the statutory Order.

22. The consultant said that when he saw the complainant at the hospital on Monday 25 June, he took the brunt of her resentment at being admitted. He too had some sympathy with her story and could have discharged her straightaway before the expiry of the statutory Order. But he found her fraught with emotion and he was by no means clear as to the full circumstances that precipitated her admission. In the event the statutory Order expired the next day and she decided to remain as a voluntary patient. The discharge certificate dated 10 July addressed to her family practitioner and signed by another SHO in psychiatry in the consultant's 'firm' indicated that she was admitted on 23 June under Section 29 and was discharged on 6 July. It also included the following: 'This lady was admitted inappropriately under Section 29 and it was therefore cancelled.' The consultant told my officer that the SHO meant by this that no further action was taken after the Section 29 Order had expired. I have found no evidence that the Section 29 Order was terminated before it lapsed.

Findings

23. The consultant's decision not to discharge the complainant before the statutory Order lapsed was one taken solely in the exercise of his clinical judgment which I cannot question.

(e) *Father's wish to visit*

24. The complainant said that her father telephoned the hospital on 25 June and spoke to one of the staff. It upset her to learn that he was advised a visit would be a waste of time. The complainant's father told my officer that he remembered that after his daughter had telephoned him on 24 June (paragraph 15) he telephoned the hospital and was told of the Section 29 Order. The next day he telephoned again and spoke to a member of staff who was discouraging about his suggestion that he would like to visit his daughter. She had told him that there was little point in coming from a distance as the complainant was only in hospital for a few days. He nevertheless visited his daughter the following day.

25. The consultant commented that there were no formal visiting hours and it was the practice to encourage relatives to visit. He wondered whether the person who spoke to the complainant's father merely meant to say that the complainant was not seriously ill and there was no need for him to rush down from a long distance to visit her. The Nursing Officer on day duty (the second NO) shared the consultant's view. He said that such a call would normally be passed to the ward sister but that, given the flexible visiting policy, it was unlikely that the reaction would have been deliberately discouraging.

26. I have seen that the Div NO when first investigating the complaint was unable to trace any member of staff who spoke to the complainant's father; the sister and staff nurse responsible for the ward on 25 June confirmed to my officer that they could not remember the call. But the sister did recall that in the course of another telephone conversation she encouraged a woman from the same area to come to see the complainant.

Findings

27. It seems likely that the complainant's father spoke to a nurse when he telephoned but I have been unable to identify her. I have no reason to think that she intended to discourage him from visiting his daughter: it seems more likely that her intentions were to have been reassuring. But those intentions were misunderstood and the remarks might have been phrased to give less scope for misunderstanding particularly as, in the event, the complainant remained in the hospital until 6 July. It was fortunate that her father took the initiative and visited his daughter the next day. Accordingly, I do not think that she suffered any significant hardship.

(f) *Pressure to remain in hospital*

28. In her letter of complaint to MIND the complainant said that after her 72 hours period of compulsory detention she was informed that the Section 29 Order had lapsed but that she was advised that in her own interest she should remain as a voluntary patient because it was normal procedure to make a further statutory Order for a period of 25 days if a patient wished to leave. The complainant told my officer that on Wednesday 27 June a charge nurse approached her while she was on the way to breakfast and said that her 72 hours were up. But she also gained an impression that she was not allowed to leave. Later the same day she asked a nurse whose first name she identified whether she

could visit the local town with another patient on the following Friday. The nurse refused her permission on the grounds that she might try to visit her children, and she added, in a matter of fact way, that should she attempt to leave she would be placed under a statutory Order for a further 25 days. The complainant said that on the following day, 28 June, she saw a doctor at a therapy session but he did not mention anything about leaving but on the day after that, a SHO asked her whether she wanted to go home. She said she had decided to stay.

29. The consultant said he would be very surprised if the complainant was threatened in the way she alleged; he said it would be foolish of the nurse since the complainant had already complained so volubly about her detention and he felt sure that she would have complained to him or another member of his staff about the remark at the time. The consultant added that the majority of his patients admitted under Section 29 remained informally and it was not his practice to detain under Section 25 and the staff knew that this was so. The second NO did not believe that any of his staff would make such a comment which was both inappropriate and unrealistic. The sister was sure that after the complainant had been informed that she was an informal patient she was aware that she was quite free to go. She felt that the complainant wanted to stay because of her personal problems. The sister, who was on duty on the morning of 27 June, had no recollection of the complainant being overpersuaded to stay, but she did recall how at meetings the complainant had asked many questions about the Sections of the Act under which compulsory admissions were authorised and at one point she had shown concern that her detention under Section 29 might be automatically extended by an Order under Section 25. The sister was sure that at the case conference on Tuesday 26 June attended by the complainant, it was made very clear to her where she stood and this did not involve the likelihood of a further statutory Order.

30. The staff nurse on duty (the SN) whose first name was the one mentioned by the complainant could not remember the patient well although she recalled thinking occasionally that she should not be in the hospital. She told my officer that normally it was accepted that a patient with informal status could go to the local town for the day; in this case she thought there were instructions at that time that the complainant should not see her children. She thought that the strategy was to introduce the complainant to her children within the hospital so that her reactions to them could be observed. When, later, the children did visit the hospital and they were so obviously pleased to see their mother, this had the effect of reassuring the staff.

Findings

31. I have found no evidence to support the complainant's allegation that she was told on Wednesday 27 June that, should she attempt to leave, an Order under Section 25 of the Act would be made. Her father told me that he visited her the previous day and that they went out to lunch together. That does not seem to me to be compatible with the allgation she makes. Furthermore she herself admitted that a SHO asked her whether she wanted to go home on Friday 29 June. I do not doubt that the complainant was dissuaded from going into the town on Friday 29 June and the SN has explained why; but I am not per-

suaded by the evidence that reference to an Order under Section 25 was made with any intention of threatening her. It was the practice of the consultant at the hospital to allow his patients voluntary status and I think it very unlikely that the kindness of the nursing and medical staff to which the complainant referred on a number of occasions in later correspondence, was suddenly replaced by a custodial attitude.

(g) *Unsatisfactory response to the complaints*

32. On 3 October the complainant wrote to the consultant to tell him that she was not proposing to attend the Day Unit again and requested her discharge. She felt she had been punished 'in the most ghastly fashion' for having lost her temper with her husband and complained among other things about the point I have reported on in paragraphs 28–30. The consultant sent a full reply on 12 October and passed a copy to the Area Administrator (the AA). On 20 October the complainant again wrote to the consultant making as her main point that no one listened to her side of the story before she was admitted. But she recognised that the hospital and the Day Unit 'were kind to me, kinder than anyone had been for a long time and I appreciate that'. However on 1 November she registered a formal complaint with the Area Administrator about her admission to the hospital. She asked specifically who applied for her admission, who provided the supporting medical recommendation and the date of his examination, under what authority the police took her to the hospital, whether the social worker was fully qualified and she requested copies of the admission papers. The complainant told my officer at interview that she found the reply by the AA on 8 November to be 'pathetic and patronising'.

33. On 28 November MIND wrote to the AHA Chairman enclosing the complainant's original letter to them of 31 July which gave very full details of her experiences. MIND asked particularly about the circumstances of her admission. I have seen that the AA then got in touch with the consultant, the Div NO, the Unit Administrator, the police and the FP. On 10 January 1980 the AHA Chairman sent a substantive reply to MIND but did not include some of the details the consultant had provided. MIND contended in their letter of 17 January that the complainant's admission had been unlawful because she had not been 'personally examined'. On 4 March the AA sent copies of the papers relating to the complainant's admission to MIND and said he could not accept the implied criticism that the hospital managers had no valid authority for detaining her. MIND remained dissatisfied and referred the case to me.

34. The AA told my officer that the normal method of dealing with complaints was to send a copy of any letter to the Area Medical Officer, the Area Nursing Officer and the appropriate officers responsible for the services involved and to ask them to investigate the complaints and reply to him. He did not follow this approach with the complainant's letter of 1 November and said he regarded it as one that needed to be referred only to the Unit Administrator at the hospital. He said that he had not enclosed copies of the admission papers at that stage because they were not supplied automatically. He had not pursued the involvement of the police at that stage and the information that the social worker was fully experienced had been obtained from the local authority. I have seen that, later, when the AA sent a report to the Chairman of the AHA about

the correspondence from MIND he thought it 'a very unfortunate case' and recommended that the reply to MIND should be limited to answering two particular questions in their letter of 28 November. I have noted that in the reply of 10 January the AHA declined to comment in general on the complainant's letter of 31 July as they felt 'it would be inappropriate to do so'.

Findings

35. The AA was entitled to rely on such information as he obtained from the local authority about the social worker but his brief reply of 8 November to the complainant did not refer to all the points she had made.. As for the reply to MIND I think it would have been defensible to say that it was inappropriate for the AHA to make any comment on the actions of the social worker and the FP. But in fact they did comment on the actions of the FP, yet failed to comment on details of events at the hospital as alleged by the complainant, including all those I have dealt with in this report. I think therefore that the reply was quite inadequate.

Conclusion

36. I sympathise with the complainant in the shock she experienced when she was suddenly transported in the company of policemen to the hospital and detained for something which she regarded as no more than marital discord. But I have not found her complaints about the conduct of the AHA in admitting her under Section 29 of the Act, to be made out. As for her subordinate complaints, the two about telephone calls did not in my judgment cause her significant hardship. The complaint about the timing of her discharge was a matter for clinical judgment but I think that her decision to remain as a voluntary patient for a further ten days and her subsequent references to the kindness she was shown refutes any suggestion that she was intent on leaving the hospital at the earliest opportunity. I have not upheld her complaints that she was told she would be detained for a longer period or that on admission she was not informed of her rights. The introduction of a written explanation of the legal basis on which a patient is admitted to which I have referred should prevent any doubt arising in future. I have criticised the replies to the complainant and MIND for which the AHA have asked me to convey their apologies in this report. This I gladly do.

Case Nos. W.80/80–81 and W.495/80–81 – Inadequate information and hospital admission procedures

Background and Complaints

1. The complainant's father, aged 54, became ill while on a trip to Milan in March 1980. He returned to England on 15 March, and was admitted to the neurosurgical unit of a hospital (hospital A), which is administered by an Area Health Authority (Teaching) (AHAX). He was discharged home on 17 March but on 12 April he became ill and had two grand mal fits. At about 7.40 pm he was taken by ambulance to the accident and emergency department of hospital A

where he was treated for a third fit by the doctor on duty and referred to the neurosurgical Senior House Officer (the SHO). It was decided that he should be cared for in a general bed. The complainant said that he was told by the SHO that hospital A was full and that the only available bed was at another hospital (hospital B) which is administered by a different Area Health Authority (AHAY). However, when his father arrived by ambulance at hospital B at about 10.35 pm the complainant was told that the available bed was at a different hospital (hospital C) and that it was this bed that had been offered to the doctors at hospital A. The complainant's father finally arrived at hospital C at approximately 1.10 am the next morning, and died there on 21 May 1980. (The complainant is fully satisfied with the care that his father had at hospital C.)

2. (i) He complains that on 12 April:

(*a*) he was not given adequate and accurate information by the doctors at hospital A and thus his father was caused more distress;

(*b*) the resident medical officer (the RMO) at hospital B told his mother that his father had to be either transferred to hospital C or be taken home;

(*c*) although his father had had three grand mal epileptic fits that day he was left alone at hospital B and the cot sides of his bed were not put up; and that

(*d*) the administrator on call for hospital B (the administrator) was not available.

(ii) He also complains that:

(*e*) AHAY's reply to his complaints was unsatisfactory; and that

(*f*) AHAX's reply to his complaint was unsatisfactory.

3. The complainant wrote on 14 April 1980 to the Area Medical Officer of AHAX (the X AMO), who replied saying that he had referred the complaint to the Area Medical Officer of AHAY (the Y AMO) and also that he would make some enquiries and write to the complainant again. The complainant received a reply from the Area Administrator of AHAY (The Y AA) on 22 May with which he was dissatisfied and he referred his complaints about that AHA to me. During the course of my investigation it appeared that consideration of the complaints about AHAY alone would not result in a report that could give more than a partial answer to the complaints and therefore the complainant wrote on 19 December 1980 to the X AMO, who had not replied as promised to his earlier letter, and received a reply on 12 February 1981. The complainant was dissatisfied with this answer. As the events are closely related I deal with the complaints against both authorities in this single report.

Investigation

4. During the investigation my officer met the complainant and his mother, and members of the medical, nursing, administrative and ancillary staff involved in the complaints. I obtained the comments of both authorities, together with copies of the clinical notes and relevant correspondence. The evidence given at the start of each section is summarised from the complainant's letters of com-

plaint to the authorities and me, as well as from information given to my officer by the complainant and his mother.

(a) *The complaint about inadequate information at hospital A*

5. The complainant said that after the SHO at hospital A had examined his father he spent a long time on the telephone and then told the complainant and his mother that hospital A was full but that he was trying to find a bed. Later he told them that there was a bed at hospital B and that the complainant's father would be admitted direct to the ward there. The complainant said that they had agreed to this move because there was no alternative but that when they arrived at hospital B they were told that the bed which had been offered was at hospital C. The complainant said that he had telephoned the SHO later that evening to ask where, according to his information, the bed was available and the SHO had said that he had been told that there was a bed at hospital B.

6. In his reply of 12 February 1981 to the complainant the X AMO said that the SHO had discussed the complainant's father's condition with his registrar (the neurosurgical registrar) who had in turn spoken to his consultant (the neurosurgical consultant). It had been agreed that the complainant's father needed a general hospital bed and that as hospital A was full the neurosurgical registrar had spoken to the Y RMO at hospital B who had advised him that there was a bed available there. The complainant's father had accordingly been transferred. AHA X confirmed this information to me and said that 'Had [the neurosurgical registrar] not been informed that the bed was available at hospital B he would certainly not have arranged [the father's] transfer by ambulance to that Hospital'. Both the neurosurgical registrar and the SHO told me that they were unaware that the bed promised was not at hospital B.

7. The neurosurgical registrar told my officer that when the complainant's father arrived at hospital A he had spoken to the neurosurgical consultant who had advised him to try to find a bed elsewhere. He said that he had asked the medical officer responsible for medical admissions to hospital A for a bed and had been told that there was none available. He said that he had then telephoned hospital B. He told my officer that he could not remember exactly what the RMO had undertaken to do or whether hospital C had been mentioned but he thought that the RMO might have said that he had just allocated his last bed at hospital B. He was certain however that the RMO had undertaken to arrange something for the complainant's father, and he had told the SHO to send a letter to the RMO at hospital B thanking him for arranging admission.

8. The SHO told my officer that the neurosurgical registrar had told him that the RMO at hospital B had been very obliging and had agreed to take the complainant's father. The SHO said he was certain that the neurosurgical registrar had not mentioned that there was a shortage of beds at hospital B or implied that they would be trying to fit him in somewhere else. The SHO said that he had not told the complainant and his mother that the father would go straight to the ward at hospital B, but that he had said that the father was going to hospital B and was expected there. He said that he had been very surprised when the complainant had telephoned him later and said that his father was being transferred again, to hospital C.

9. In his reply of 22 May 1980 to the complaint the Y AA said that the RMO had been asked for help by the neurosurgical registrar as there were no beds available at hospital A. The RMO, who had just allocated his last male medical bed at hospital B, had said that they were unlikely to be able to help but that he had suggested sending the complainant's father to hospital C. The Y AA said that the RMO had offered to see the patient at hospital B before sending him to hospital C as this was the normal policy for admissions there. AHA Y told me that if the patient had been told at hospital A that the bed offered was at hospital C 'a lot of the subsequent confusion could possibly have been avoided'.

10. The RMO confirmed to my officer the account given in the Y AA's letter to the complainant and said that he had explained to the neurosurgical registrar that the bed was at hospital C and that when he made this call two other doctors were present in the room. The RMO said that he had followed a standing instruction that all patients to be admitted to hospital C had first to be seen by a doctor at hospital B. A medical registrar who was the RMO's immediate senior and the consultant physician on call (the consultant physician) confirmed to my officer that this was the policy for admitting patients to hospital C.

11. My officer spoke to the doctors who, according to the RMO, had heard him speak to the neurosurgical registrar. One said that she was absolutely certain that the RMO had explained that the patient would have to be seen at hospital B first because that was the rule, but that the patient would be sent to hospital C afterwards. The second doctor said that he remembered that the RMO had said that hospital B was very full and had then gone to another telephone and made arrangements for a bed. He had then returned to explain what he had arranged. This doctor could not say categorically that the RMO had said the bed would be at hospital C but he thought that he must have done so.

12. I have seen that the SHO made an entry in the medical notes on the evening of 12 April which concluded '[neurosurgical registrar] arranged [with] RMO at [hospital B] for admission. Note sent', and that the note began 'to RMO [hospital B] re ——. Thank you for accepting this 54 year old man'. The accident and emergency card for hospital B bears an entry by the RMO which reads 'Referred from [hospital A]. . . . No medical beds at [hospital A] [therefore] pt accepted here. [The hospital A] informed from onset that pt would be transferred from here to [hospital C]. Relatives now most unhappy about this'.

Findings

13. I am in no doubt that it was not made clear to the complainant and his mother, but should have been, that the patient would be transferred to hospital C after being seen at hospital B. It is not necessary for me to determine whether the doctors at hospital A or those at hospital B were principally at fault. I am inclined to think that there were errors on both sides. I uphold this complaint.

(b) *The complaint that at hospital B the RMO told the complainant's mother that her husband had either to be transferred to hospital C or to be taken home*

14. The complainant said that when the RMO had told them that the patient would have to be moved again, this time to hospital C, they had been very upset,

especially when they learned that it was nine miles away. The complainant's mother had then asked what would happen if they did not want him to go there and she was met with the reply 'either he goes there or you take him home'. She said that she had been very distressed by this as she knew her husband only had about three weeks to live and although she had wanted to look after him at home, she knew she could not cope with his medical problems.

15. In his reply to the complainant the YAA said that the RMO had tried to explain that they were trying to do their best in very difficult circumstances and it was unfortunate that the complainant had interpreted this as indicating a 'take it or leave it' attitude, which was not intended. The AHAY did not make any comment to me about this aspect of the complaint.

16. The RMO told my officer that the complainant's mother became very upset when he explained that he had told the doctor at hospital A that the patient would be going to hospital C if he was fit for transfer. After he had examined him he had decided that he was fit to be transferred to hospital C and had seen the complainant's mother to explain again that he had been trying to help hospital A, and that he had arranged a bed at hospital C. He had explained that there were no beds at hospital B. He said that the complainant's mother asked him twice what would happen if they did not want the bed at hospital C and that he had then said that he supposed the patient would have to go home. He said she had not believed him when he said that he had told hospital A that the bed he had offered was at hospital C.

17. The RMO told my officer that as he could admit patients only to hospital B and to hospital C and as the only bed available was at hospital C he had no alternative to offer to the complainant's mother. He had tried to explain this to her. The state enrolled nurse who was in charge of the accident and emergency department at hospital B (the SEN) told my officer that she had heard the RMO explain that the patient would have to go to hospital C or be taken home. She said that he explained this politely and that he was not rude in any way.

Findings

18. I find that the RMO was replying factually to the question put by the complainant's mother and that he was not in any way offensive. I do not uphold this complaint.

(c) *The complaint about the failure to put up the cot sides of the bed*

19. The complainant said that on his arrival at hospital B his father had been put in a side room and that someone had taken his blood pressure, temperature etc. He and his mother, together with his grandmother and uncle who had by then joined them, had been left sitting outside the room. He had asked someone if they could go in and was told 'no'. He said that after about fifteen minutes because he was very anxious he did go in to see his father who was alone and the cot sides of his bed were down. He said that in his opinion the sides should have been up because his father had had three fits and been given valium; he could have had another fit or fallen out of bed. The complainant said that he put the cot sides up and then went to the sister's office. He said that he had told the RMO

and SEN what he had done. A pupil nurse (the pupil) had then been sent in to sit with his father and the complainant had also stayed with him.

20. The Y AA, whose reply to this aspect of the complaint was based on a report from the Senior Nursing Officer (the SNO), told the complainant that the SEN was aware of the patient's problems and in her opinion it was not necessary to put the cot sides up when she left him for a brief period to summon the pupil to assist. He said that the SEN remembered asking the complainant to stay with his father during this period, and that the pupil nurse then stayed with him until he was seen by the RMO. He also said that if the complainant's father was left alone it was only for a matter of minutes. AHA Y did not comment to me on this aspect of the complaint.

21. The SEN told my officer that before the complainant's father arrived the RMO had told her that he was terminal and epileptic and that when he arrived the ambulance men had put him into a room and she had gone to see him. She said that in her opinion cot sides were not required, although they could have been put up. The SEN said that on her way to fetch the pupil she had asked the complainant to stay with his father. When my officer told her that the complainant said he had not been told this she said that as he was making a bit of a fuss he may not have heard her. She said that he had made no response to her request. The SEN said she had gone directly to the dressing room and asked the pupil to leave what she was doing and go to the complainant's father. The pupil had gone directly back to him and the SEN said that this would have taken two to three minutes at the most.

22. The pupil told my officer that on the instructions of the SEN she had gone straight to the patient who was lying quietly in a bed of which the sides were down and she had 'done the observations' and had then returned to the dressing room. She said that as far as she could recall no relative had asked to go in and that the patient had been left on his own with the cot sides down. The pupil said that about five to ten minutes later she went back to him and then the cot sides were up and the SEN had asked her to stay with him. The pupil said that she had not put the cot sides up because the patient was quiet and his observations were normal. She told my officer that she had not known that he had had three fits that night or that he had had valium and that if she had known she would have put the cot sides up.

23. The SNO told my officer that the pupil had not been available when he made his investigations.

Findings

24. Decisions about whether or not cot sides should be put up and whether a patient may safely be left are actions taken in connection with the care of a patient and are not ones which I may question if I am satisfied that they were taken solely in the exercise of professional judgment. I am satisfied that that was the case here and I therefore make no comment on this complaint.

(d) *The complaint that the administrator was not available*

25. The complainant said that he had wanted to speak to the administrator for hospital B and said that hospital B's switchboard operator had given him

her telephone number which he tried a couple of times but that there was no answer. The operator had then called the Nursing Officer (the NO) for him.

26. The Y AA told the complainant that he was sorry that the complainant had been unable to contact the administrator who they had been assured was available by telephone that evening. But he added that he did not see how even if the complainant had complained to the administrator it would have altered the situation. AHA Y told me that it was regrettable that the complainant was not able to contact the administrator and that they had apologised for this.

27. The administrator told my officer that she had not been staying at her own home on the night of April 12 but that she had notified hospital B and another hospital of the telephone number of the flat at which she would be staying and that she had said that if she went out she would carry her 'bleep'. She said that she had gone out but that she had been within the range of her 'bleep', which she had with her. The AHA told me that the on-call administrator had notified the switchboards at the two major hospitals of the seven for which she had been responsible.

28. The switchboard operator told my officer that he recalled trying to contact the administrator for the complainant. He said that when he came on duty that evening there had been a note (which I have seen) giving an alternative number for the administrator, and he thought that he had tried both that and her usual number. He said he did not think that he had tried to 'bleep' the administrator but in view of the time that had elapsed he could not be sure. However the General Administrator told my officer that he spoke to the switchboard operator on receipt of the complaint and that he had then said that he had tried to 'bleep' the administrator.

Findings

29. The purpose of having an administrator on call is in order that he may be consulted about problems, whether or not he can resolve them. I uphold the complaint that the administrator was not available.

(e) *The complaint about the reply by AHA Y*

30. The complainant said that he had found the reply from the Y AA most unsatisfactory. He said that he had been upset that it had arrived on the day of his father's funeral and that he disputed the accuracy of its statements that his father had only been left for a few minutes, that the administrator had been available by telephone, and that there had not been a 'take it or leave it attitude' over the offer of the bed at hospital C. He also said that there was no explanation about why the normal policy of seeing a patient at hospital B before sending him to hospital C had to be followed when his father had already been assessed at hospital A.

31. AHA Y told me that they were sorry the complainant found the Y AA's answer to his complaint to be unsatisfactory but they felt that the various points raised had been answered fully and accurately.

32. I have seen that when he received the complainant's letter from the X AMO the Y AA told the complainant that he would make enquiries and write again as soon as possible. He obtained the written comments of the consultant physician, the RMO and the SNO (who had made enquiries of the NO and the SEN) and he replied to the complainant in a letter dated 22 May. The letter gave the information quoted in paragraphs 9, 15, 20 and 26 of this report and also invited the complainant to contact the Y AA or to meet the consultant physician if he wanted further information, and said 'I am well aware of your concern for your father's well-being and I sympathise with you; I must say, however, that you could have helped the situation by allowing the members of the medical and nursing staff to get on with their work without interruption'.

33. The Y AA told my officer that he recognised that someone should have enquired about the patient's condition and that the letter to his son should have expressed sympathy for his death, but apart from this he thought that the letter he had sent was adequate. He said he thought he had been right to criticise the complainant's behaviour and that if he had made enquiries about the information given to the complainant at hospital A this would have caused delay. He also pointed out that he had offered to follow up the complaint if the complainant remained dissatisfied.

Findings

34. The enquiries into the complaints by the Y AA were insufficiently thorough in respect of the complaint about the cot sides and whether the patient was left alone. The reply about the availability of the administrator was inaccurate. AHA Y told me (see paragraph 9) that if hospital A had given accurate information to the complainant a lot of the subsequent confusion could possibly have been avoided, but they made no approach to AHA X before making that assertion. I uphold the complaint that AHA Y's reply to the complaints was unsatisfactory.

(f) *The complaint about the reply by AHA X*

35. The complainant said that the reply he eventually received (see paragraph 37) from the X AMO had said that they had been advised that there was a bed available at hospital B.

36. In their comments to me AHA X said that the complainant's letter of complaint to the X AMO had been wholly directed to events at hospital B after his father was transferred from hospital A. They said that had the neurosurgical registrar been informed that the bed was not available at hospital B he would not have arranged the transfer there.

37. I have seen the correspondence about this complaint. The Y AMO wrote to the complainant on 17 April 1980 saying that he had passed the complaint to the Y AMO, but that he would enquire why it was necessary for his father to have been transferred to hospital B in the first place and would write again when he had an explanation. However he did not do so and the complainant wrote to him again on 19 December 1980. The X AMO replied on 12 February 1981 apologising for his failure to reply and saying that as he had heard that the

complainant had referred the matter to me he had thought that he would receive an explanation through my Office. He said that he had been informed that hospital A was full that night and that the neurosurgical registrar had therefore telephoned hospital B where the RMO had offered a bed.

38. The X AMO told my officer that there had been a misunderstanding about answering the complaint. He said that he had shown the complainant's letter to the District General Administrator (Operational Management) (the DGA) and the chairman of the Medical Executive Committee (the MEC chairman), who had agreed that the complaint should be sent to AHA Y. But the X AMO said that he had also expected a response from the DGA and the MEC chairman. He had also spoken to the neurosurgical registrar about the complaint. He said that he acknowledged that he should have dealt with the complaint more expeditiously, but that when he had been prepared to take further action he had learned that I was investigating the complaint and he thought therefore that it would be inappropriate for him to proceed.

39. The neurosurgical registrar told my officer that he had told the X AMO that he did not remember exactly what was said in his conversation with the RMO. The DGA told my officer that he remembered the X AMO showing him and the MEC chairman the letter of complaint and that they had advised him to send it to AHA Y. He said that he had not thought that the X AMO expected him to make further enquiries and so he had not done so. The MEC chairman told my officer that he recalled the X AMO showing him the letter of complaint and that he had thought that the complaint was solely against AHA Y.

Findings

40. The X AMO should have kept his promise to write to the complainant again. Paragraph 5 of Schedule 13 of the National Health Services Act 1977 provides that a relevant body may continue to take action even though I am conducting an investigation. I also find it disconcerting that nothing was done to see if there was any need to improve the liaison between the hospitals concerned when this complaint was considered by AHA X. I uphold this complaint.

Conclusion

41. I have given my findings in paragraphs 13, 18, 24, 29, 34 and 40. It is not always possible for a patient taken to an accident and emergency department of a hospital to be admitted to a bed in that hospital. Transfer arrangements may be routine to those who operate them but are individual to each patient and his relatives, to whom they need to be clearly explained. In this case I consider that both authorities have been guilty of maladministration not only in respect of the specific failures which were complained about and which I found justified, but in their failure singly or jointly to take any action to obviate similar problems in the future. They have each assured me that they will do so now. AHA Y have told me that they will review the procedure for the admission of patients who have already been examined to hospital C and that steps have already been taken to improve the 'on-call' arrangements. Both AHA X and AHA Y have asked me to convey through this report their apologies to the complainant and his mother and I gladly do so.

Case No. W.82/80–81 – Disclosure of medical information to employers

Complaint and background

1. The complainant, a student nurse employed by an Area Health Authority (Teaching) (the AHA(T)), was treated by a consultant neurologist (the consultant) at a hospital (the hospital) from October 1979 onwards. She complains that:

(*a*) the consultant disclosed medical information to her employers without her knowledge or consent; and that

(*b*) the AHA(T)'s replies to her complaints were unsatisfactory.

Investigation

2. During the investigation I obtained the comments of the AHA(T) and other relevant papers. One of my officers interviewed the medical, nursing and administrative staff concerned. He also met the complainant. (The dates of the events as given in the narrative are not in dispute.)

(a) *The complaint that the consultant improperly disclosed medical information to her employers*

3. In correspondence and in her interview with my officer, the complainant said that she was employed as a student nurse by the AHA(T) and that on 7 October 1979 she had been admitted to the hospital with a diagnosis of viral labryinthitis. She was discharged on 15 October and attended a follow-up appointment on 8 November when she was seen by the consultant and was informed that the previous diagnosis was incorrect and that she was suffering from multiple sclerosis. She said it was at this appointment that the consultant had first advised her to give up nursing. She had been surprised as she thought she could still cope with her job despite the new diagnosis. However she said that the consultant told her she was medically unfit to continue in nursing and the matter had already been discussed with the Director of Nurse Education (the DNE). The complainant said she continued working but at a subsequent follow-up appointment on 28 November she realised that the consultant was 'going to make a fuss' as he insisted she should give up her nursing career 'immediately'. The next day (29 November) she was readmitted to the hospital and she said the consultant again told her that she had got multiple sclerosis and should give up nursing immediately. She said that she asked the registrar and the houseman on the ward what she should do and they told her that there was no medical evidence to suggest that she should not carry on with her career.

4. The complainant said that on 3 December her senior tutor at the school of nursing (the tutor) met the consultant by chance when she was on her way to visit the complainant and he had asked the tutor 'to have a word'. The tutor told her that the consultant had said that he felt that she was emotionally unfit to continue in nursing and her employment should be terminated. The complainant said that she therefore decided to look at her medical file which was kept outside the ward. (She told my officer that she realised that reading her file was not the proper thing to do but as she was sure the consultant was going behind her back and acting in an unauthorised manner this was the only way she could

get the information she needed to pursue her complaint. She said that she had not told anyone other than me that she had read her file.) She said that in the file she saw a letter from the consultant to her divisional nursing officer (the Div NO) dated 28 November saying that he was not at all happy about her continuing in nursing and asking the Div NO 'to give him a ring' so they could lunch together to discuss 'this highly confidential matter'. The complainant said that she realised that the real reason the consultant wanted her to cease nursing was because he was convinced that as she had worked in both California and Morocco she 'had if not still were exposed to excessive doses of drugs' (*sic*) and that he also expressed this opinion in a letter to her family practitioner (the FP). The complainant said that a few days later she was contacted by the Occupational Health physician (the OHP) who said that he had been asked by the school of nursing to examine her because of what the consultant had said. The complainant said that the OHP told her that the consultant should not have discussed her case with the school of nursing, and he had himself telephoned the consultant to say that he would not examine her unless with the complainant's prior permission the consultant sent a written report.

5. The complainant said that she felt very strongly that the consultant's opinion could well have 'carried the day' in any assessment of her ability to continue into a second year of nursing training and that as the consultant was not a psychiatrist he was in no position to comment on her emotional stability. She added that she had continued as a student nurse and her subsequent nursing assignments had included duty on the consultant's ward.

6. The consultant told me that he did disclose the complainant's notes to her employers but only after obtaining her written consent on 20 December. The AHA(T) told me that the consultant had denied any breach of confidentiality but confirmed that he had advised the complainant that she should not continue with her training as a nurse.

7. The consultant told my officer that he had diagnosed the complainant as suffering from multiple sclerosis. He said that in his opinion her attitude was insolent and aggressive and this, together with the fact that she suffered from multiple sclerosis convinced him that she was unsuitable to continue in the nursing profession. From his observations of her when she attended his clinic, and knowing of her travels in Morocco and California, he had thought that there was a strong possibility that she had taken drugs in the past, if she was not doing so currently. He said that he thought that these were relevant matters for him to discuss with the tutor. The consultant told my officer that he had taken the view that nursing staff were not employed by other members of the nursing staff but by the AHA(T). He had regarded the tutor and the DNE as professional colleagues and he remembered speaking to the tutor on a ward round. He had discussed the possibility of drug abuse and the complainant's behaviour. Although he could not remember speaking to the Div NO he did not think it mattered if he had as he would have regarded him too as a professional colleague and not the complainant's employer. He was emphatic that he had not written to the Div NO about the complainant.

8. The consultant said that when the OHP telephoned him on 6 December 1979 asking for a report on the complainant's condition he had replied 'I am first of all going through the necessary formality of obtaining her consent as, I

am sure you will appreciate, there is a question of confidentiality as I presume you are acting on behalf of her employers in this matter'. He then wrote to the complainant seeking her permission which, in a letter dated 10 December, she refused to give pointing out that the consultant had not sought her permission before recommending to her tutors that her employment be terminated on the grounds of her emotional instability. The consultant therefore wrote to the OHP on 12 December saying that he had been asked by the complainant not to discuss the case with anyone. He also wrote a letter marked 'Private and Confidential' to the complainant assuring her that he had not recommended the termination of her employment 'on the grounds of your emotional instability or indeed on any other grounds.' He did however repeat his personal advice that it would be best if she gave up her employment. However, he said, the OHP had seen her in the meantime and she had agreed that the consultant could send a copy of her medical records to him. The OHP wrote to the consultant on 27 December enclosing the complainant's written permission and the consultant sent him her records on 14 January.

9. The tutor told my officer that she knew the complainant very well. The only time she could remember speaking to the consultant about her was on 3 December. He had met her on her way to visit the complainant and as far as she could remember he had said, 'what do you think of [the complainant] as a person?' He added that he was not happy that she should continue in nursing and said that he was worried that she had been or was taking drugs. The tutor told my officer that she had viewed the complainant as one of her students and not as a patient and neither then nor since had she seen her medical records. She said she had not regarded her conversation with the consultant as a breach of confidence but said she was aware that it would have been if she had looked at the complainant's files. She had received nothing in writing from the consultant.

10. The tutor wrote on 3 December 1979 to the DNE 'In Confidence' saying 'I have spoken with [the consultant] this morning . . . says he has telephoned [the Div NO] whom he knows well because he did not [know] who else to contact . . . under no circumstances does he feel [the complainant] is fit to nurse, and he is willing to put this in writing so that she can have her training terminated. He asked me not to speak of this with [the complainant] with whom he has not yet discussed the matter himself. After my conversation with [the consultant] I went to speak with [the complainant] who asked me directly if [the consultant] had said she should give up nursing. I did not answer directly, and [the complainant] hastened to assure me that if he did say this she would fight it and would ask another consultant for a second opinion.'

11. The tutor also wrote a 'file note' dated 18 July 1980 saying that following her discussion with the consultant the DNE advised her that in the circumstances and in accordance with AHA(T) policy she should ask our OHP to see the complainant with a view to determining whether or not she was fit to continue in nursing. Because there had been previous unsuccessful attempts to get her to see the OHP the tutor attempted personally to arrange for the complainant to see him but the note records that the OHP became quite angry and said that as the tutor knew the details of the complainant's illness the consultant must have breached medical confidence in discussing the case of a patient. The OHP refused to see the complainant and the tutor said that therefore she did no more.

12. The OHP told my officer that he had first become involved when the tutor had sent on behalf of the DNE a standard letter to the occupational health department. He had spoken to the tutor on 6 December and had been surprised by her knowledge of the complainant's medical history. He had asked her how she knew of it and she said the information had come from medical staff on the ward. He had spoken to the Area Medical Officer about the possible breach of confidentiality and had been advised to speak to the consultant. He had telephoned him and there had been 'quite an argument.' The consultant did not agree he had broken any confidences and would not accept that he had disclosed information to the complainant's employers. The OHP told my officer that he sympathised fully with this complaint. (He also told my officer that following his examination he was not able to certify that she was not suitable to continue in her training as a nurse and had told the AHA(T) so.)

13. The DNE told my officer that he had first heard of the case when the tutor had spoken to him about the complainant, but he was unable to say exactly when that was. He had not, as far as he could recall, spoken to her and could only remember 'a passing conversation' on the matter with the consultant. He stated that the complainant's referral to the occupational health department was in accordance with their routine practice.

14. The Div NO told my officer that as far as he knew he had not met the complainant, and could not recall any details of her case. He had received nothing in writing from the consultant about the complainant; he had received one telephone call from the consultant saying he wanted to discuss a student nurse and the Div NO had replied that this was not any part of his responsibility and was a matter for the school of nursing. He did not know what the complainant's medical diagnosis was or anything other than that the OHP had considered her suitable to continue nursing.

15. The consultant's registrar (the registrar) told my officer that he remembered that at an out-patient appointment the complainant had been very irate when she had been told that there was probably no effective treatment for her symptoms. She had left in the middle of a consultation saying something like 'you will all get me sacked from my job.' He spoke to the DNE, not disclosing any medical information but seeking an assurance that the complainant was not in danger of imminent dismissal as he felt that she needed to be reassured that people were not 'ganging up' against her. In a letter to the FP dated 25 October, the day after the consultation, the registrar explained what had happened and said that the DNE had told him that a decision about terminating the complainant's employment would be taken only after consultation between the OHP and the consultant.

16. Neither the complainant's medical records nor the Div NO's files contain a letter as described by the complainant in paragraph 4.There is a letter in her medical records from the consultant to the FP dated 8 November which refers to the complainant as a difficult person and says 'I felt all along that this lady may have in the past, if not now, been exposed to excessive doses of drugs and I have advised her particularly to desist from taking drugs unless they are absolutely necessary'.

Findings

17. Having regard to the serious nature of an allegation of breach of professional confidence and to the evidence which had been assembled by my officers, I decided that I ought to give the consultant an opportunity to address me personally on the matter and to make such representations about it as he saw fit, with or without the assistance of a friend or adviser. In the event, he came alone to see me on 16 April 1981 and I questioned him and listened to what he had to say. He admitted to me that he had spoken about the complainant's health, and her fitness to be a nurse, to the tutor and that in doing so he was using information which he had obtained from the complainant at a time when she was his patient. The consultant was on this occasion disposed to argue that his disclosure to the tutor was justifiable as one or more of the familiar exceptions to the rule about confidentiality. But after taking time for reflection he conceded that he had been in error and accepted the responsibility for what had occurred. I think that that was entirely the right conclusion upon the facts and I agree with it, thus upholding the complaint. The consultant asked me to convey to the complainant through this report his unreserved apologies for any offence he might have caused her. I am very glad to do so.

18. I fully appreciate how easy it must be, when a member of staff becomes a patient, to overlook the new and special relationship which may have sprung into being overnight and I sympathise with any doctor who falls into the trap of discussing the health of a patient who is also a member of staff, with other members of staff without realising that he may thus have put himself technically in breach of his duty to the patient. This is what occurred in the present case and it seems to me to have been no more than a momentary lapse for which the consultant's apologies are a sufficient redress. That in my judgment should be an end of the matter so far as the consultant is concerned.

Conclusion

19. The really important consideration which emerges in this case is that where an OHP is appointed he is the person charged with the supervision of the health of staff and their fitness to continue in employment. And it is to him to whom all representations on such a matter should be made in the first instance. AHAs should remind staff of the importance of this.

(*b*) *The complaint that the AHA(T)'s replies to her complaints were unsatisfactory*

20. The complainant told me that she wrote to the General Nursing Council (the GNC) on 7 December 1979 complaining of the breach of confidentiality and asking them to look into the matter on her behalf. She sent a copy of that letter to the hospital administrator and the OHP. On 21 December the complainant wrote to the sector administrator (the SA) at the hospital asking him to investigate her complaint officially. She said that the SA sent a copy of her complaint to the consultant who avoided answering the allegation and simply insisted that he obtained her permission before writing to the OHP. She said that the matter was then referred to the headquarters of the AHA(T) where it was dealt with by the general administrator (the GA) and the complainant said that she was invited to see him. She said that the GA had considered the consultant's written reply totally non-committal and therefore he had telephoned the consultant who had simply insisted that he could not recall ever having spoken

to the tutor and suggested that any information the nursing staff had they had received by going on the ward and reading her file. The complainant told my officer that the advice she had received from the GNC was to consult a solicitor.

21. The AHA(T) told me that the complaint had been brought to the attention of the consultant who denied any breach of confidentiality but confirmed that he had advised the complainant that she should not continue with her training as a nurse. The AHA(T) said that at the time the complaint was made the DNE had stated that there was no intention of terminating the complainant's service, and that she was interviewed on 5 February by the GA and reassured as to her future employment with the Authority.

22. The SA told my officer that he had sent a copy of the complainant's letter of 7 December to the GA as in his view the matter raised by the complainant was a matter of principle and should be dealt with and replied to by the AHA(T). He also sent a copy of her letter to the Area Nursing Officer and to the consultant.

23. The GA told my officer he had invited the complainant to see him about the complaint but he did not keep a record of the meeting. He told my officer that he had treated her as a complainant and not as an employee. No written reply was made to her complaint. The GA said that he had spoken to the consultant but the consultant did not think he had done anything wrong. He had a very clear impression that the complainant was deeply concerned about what had happened and he advised her to go to a lawyer or to refer the matter to me. He did not consider it appropriate for the AHA(T) to make an apology.

Findings

24. This complaint was a matter of considerable concern to the complainant and as she had submitted it in writing to the AHA(T) and they knew she had not been satisfied by the interview with the GA they should have replied to her in writing. I uphold this complaint.

Conclusion

25. I consider that the complainant is entitled to receive an apology for the way her complaint was handled and at the request of the AHA(T) I am glad to convey one on their behalf in this report.

Case No. W.132/80–81 – Care given during premature birth of twins

Background and complaint

1. The complainant's wife was admitted to hospital (the hospital) on 2 April 1980, when she was thought to be about 31 weeks pregnant and her twins were delivered on 10 April. The complainant, who was present at the hospital during the confinement, complains that:

(*a*) the theatre light in the delivery room was dirty and when he moved it because his wife was too hot dirt fell on her;

(*b*) the complainant's wife was not examined in reasonable privacy in that the Senior House Officer (the SHO) removed her bedclothes and performed a vaginal examination without closing the door of her room, which opened on to the corridor.

(*c*) he was asked to leave while a drip was inserted and was told that he would be informed when he could return, but this was not done and there was a long delay before he found out, from his brother, that he could return;

(*d*) the presence of a medical student (the student) in the particular circumstances of his wife's confinement was unreasonable and proper consent had not been given by her;

(*e*) during the birth the SHO concentrated on instructing the student and ignored the emotional needs of the complainant and his wife, and that

(*f*) the response to his complaints by the Area Health Authority (the AHA) was unsatisfactory.

Investigation

2. During my investigation I obtained the AHA's written comments, and copies of the correspondence about the complaint as well as the medical and nursing notes of the complainant's wife and her twins. I also received written evidence from the student, who has now left the UK. My officer interviewed the complainant and his wife and members of the medical, nursing and administrative staff involved. The evidence of the complainant and his wife given below under each aspect of the complaint is summarised from their interview with my officer and from the complainant's letters to the AHA and to me.

(a) *The complaint that the light was dirty*

3. The complainant said that his wife had become very hot in the delivery room and as he could see that the theatre light was on a swivel he had moved it. He said that a lot of thick dust and dirt had fallen on his wife, and when he tried to brush it away it left black smuts. The complainant's wife said that it was old dirt and in her opinion the light had not been cleaned for days. The complainant said that he had not complained at the time because he thought the nurses would be annoyed that he had moved the light and he would be made to leave. He said that later he had told two nurses in the Special Care Baby Unit (the SCBU) about it and had been told that such problems occurred because the nurses could not perform duties which were the responsibility of the cleaning staff.

4. In their reply to the complainant the AHA said that the theatre lights were cleaned daily by the midwifery staff, weekly by the domestic staff, and by outside contractors on a more infrequent basis. They said that they had been surprised to receive this complaint but that the situation would be kept under review.

5. The Divisional Nursing Officer (Midwifery) (the Div NO) told my officer that the lights were cleaned and checked routinely every shift, and that the delivery suites were also cleaned between each birth. She said that she made frequent checks of the delivery suites and that she had never seen any dirt on the lights and that she had been unable to identify anyone who had spoken to the complainant about difficulties with regard to cleaning.

6. The staff midwife (the midwife) who was present at the delivery told my officer that the light was cleaned after every delivery and suggested to my officer that the complainant and his wife might have seen a white powder, which was

used liberally, fall off the light. A sister in the SCBU (the first sister) said that the complainant had complained to her that the light was dirty but as it was cleaned very frequently she found this difficult to believe. Two other nurses also said that the lights were cleaned frequently. The SHO said that the light was moved very frequently and he felt that he would have noticed if it had been dirty.

Findings

7. From the consensus of evidence I have been given by the staff it would seem unlikely that the theatre light would have been in the dirty state described by the complainant and his wife. But on the other hand, the complainant and his wife had no reason to invent the story. I find the evidence about this incident conflicting and since I am left in doubt as to where the truth lies I am not satisfied that the complaint is made out.

(b) *The complaint about the circumstances of the wife's examination*

8. The complainant said that the SHO had carried out a vaginal examination of the complainant's wife in the early hours of the morning and that the nurses had done the same simple examination at least a dozen times that night without removing his wife's sheet, and that they had been discreet although the door might have been open during these examinations. He said that the SHO who had appeared very tired had left the door open and had removed the sheet and 'poked around' in full view of anyone who might have gone past. The SHO had not replaced the sheet after his examination. He said he thought that the doctor should have had more concern for his wife's dignity.

9. The AHA in their reply to the complainant agreed that the examination had taken place in the early hours of the morning and said that the SHO had received a number of calls during the night. They said that nevertheless, in general, all staff tried to recognise the importance of the dignity of the patient and 'we do regret those occasions when patients feel that we have failed in this regard.'

10. The SHO told my officer that he could not remember the birth itself, although he could recall speaking to the complainant and his wife the next day. He said that from his notes he had seen that he had examined the wife at about 12.30 am and decided that it could be some time before she would deliver. At about 5 am he had been called by the midwife and had examined the wife again and found that the head of the first twin was well down. He said that it was medically necessary to remove the wife's covering. He also said that it was not his policy to leave the door open when he examined patients but if he had done so he would willingly apologise.

11. The midwife told my officer that she had called the SHO when she found the complainant's wife was in the second stage of labour, and had got everything ready for him. She had been present for the examination at about 5 am. The midwife said that she always made sure that a nurse was present during an examination even if the husband was there as she thought that it was nice for her patient to have another woman present. She said that if the SHO had left the door open she would have shut it. The only time that the door might have been left open was later when the complainant left, so that it could show a light to guide him if he wanted to come back. In her statement to the AHA the midwife said that the SHO 'was throughout the procedures very professional and con-

siderate to [the complainant's wife] and at all times as far as was possible in the circumstances considered [her] dignity and privacy . . . as far as I am aware the door was not left open but it may have been while [the complainant] was out of the room to make it easier to find his way back.' The first sister told my officer that she had asked the complainant's wife if the actions of the SHO had upset her and she had said 'not at all.'

12. Both the Div NO and the Nursing Officer (the NO) told my officer that only people involved in the patient's care would have needed to go down the corridor as far as her room at that time. My officer saw that the delivery room which the complainant's wife occupied was the last room along the corridor, except for an operating theatre which she was told was not in use that night. Moreover she saw that the bed was behind the door and therefore if anyone had been passing they would not have seen the complainant's wife.

13. The clinical notes show that the SHO performed a vaginal examination at 12.30 am and that between then and 5 am the midwife measured the wife's temperature, pulse, blood pressure and contractions eight times. They also confirm that at 5 am a vaginal examination by the midwife showed that the cervix was fully dilated, and that the midwife then notified the SHO.

Findings

14. The way in which the SHO thought it necessary to carry out his examination of the complainant's wife is a matter for his clinical judgment on which I may not comment. Although the door may have inadvertently been left open I am satisfied that in the circumstances of the time and of the layout of the room there was no intrustion upon the wife's privacy. I do not uphold this complaint.

(c) *The complaint that the complainant was asked to leave the labour ward and not told that he could return*

15. The complainant said that at about 5.15 am, after the SHO's examination, the midwife had said that they were going to put up a drip and advised him to 'go and have a cigarette or go to the toilet or something'. She had said that he could wait in the day room and that 'it will only be a couple of minutes and I'll come and fetch you'. The complainant said that he seemed to be waiting there for hours and he had thought that something must have gone wrong. He said that he had just made up his mind to go back anyway when he met his brother who had called in to ask what was happening. His brother told him that he had seen a nurse who had said that if he saw the complainant he was to tell him to go round as his wife was about to have a baby. The complainant said that he had returned just before the first twin was born at 6.45 am. He said that when he arrived back the room was full of people and that he feared something serious was going wrong. He was hesitant about going into the room. He told my officer that he did not know why the nurses had not sent for him as in many ways he had felt that they wanted him there and were pleased to involve him.

16. The AHA did not refer to this complaint in their reply to the complainant.

17. In a written statement to the AHA the midwife said that the complainant was made to feel welcome and that he could 'come in and out as he wished' but that she had been unable to send for him because she was caring for his wife.

She told my officer that it was possible that the SHO had suggested to the complainant that he should go outside when the drip was put up but that she was sure that he had been present for most of the one and a half hours between the drip being inserted and the first birth and said that she would have looked for him if he had been absent for no reason, as husbands were encouraged to be present. She said that during the second stage of labour the complainant got anxious and queasy and said he was not sure if he wanted to see the twins born. The midwife said that she had told him to go for a walk if he wished and to come back at any time that he wanted to do so.

18. The SHO could not recall the delivery; and a senior house officer in paediatrics (the paediatric SHO) and a pupil midwife (the pupil) who were present at the births could not recall whether the complainant had been present. In her written evidence the student said that she remembered the first birth but did not recall whether the complainant had been absent before it.

Findings

19. In view of evidence about the emotional strain on the complainant at the time I believe the midwife's account of this episode is likely to be the more accurate and that the complainant left the labour ward of his own volition. It was therefore up to him to decide when he wanted to return and I am satisfied that the staff would have been welcoming to him. I do not uphold this complaint.

(d) *The complaint that the presence of the student was unreasonable and that the complainant's wife had not consented to it*

20. The complainant's wife said that when she had first seen the student, at about midnight, she said 'do you mind if I sit in on [the birth]' and she had replied that she did not. She said that she had not slept since her waters broke, had been in labour for the best part of a day, and was very frightened because she knew her twins were at risk.

21. The complainant said that as his wife had first gone into hospital for rest she had not minded participating in teaching and she had not, at that time, objected. If the birth had been normal he would have raised no objection. However he said that after her waters broke unexpectedly his wife had had no sleep for two days and nights and was very frightened and the complainant said that although his wife had been asked by the student if she could attend the birth he felt that the staff should have realised that she was in no condition to give a proper answer. The complainant also said he had been there to look after his wife and that despite the fact that he had been present with his wife for six hours that night no-one had taken the trouble to ask if he minded. He would not have objected if the birth was going to be straightforward, but he felt that there had been an unfair intrusion in what, because of the difficulties involved, they had half expected to be a time of grief.

22. The AHA in their reply to the complainant said that they appreciated that the presence of students was a sensitive issue and that they took steps to try to ensure that if a patient did not wish to participate in the teaching of students, that wish was respected. They said that the booklet which the complainant's wife would have received when she arranged to go to the hospital informed patients of the role of the hospital in teaching, and asked them to make their wishes known

to staff if they did not wish to take part. The AHA also said it was important for students to gain experience of difficult, as well as of normal, deliveries.

23. The Department of Health and Social Security (the Department) issued guidance in their circular HM(73)8 as amended by HC(77)18 to health authorities about patients' involvement in medical student teaching. The guidance says that any hospital where teaching takes place should include in its patients' booklet an outline of what it might involve and a clear statement that patients may decline to participate without prejudice to treatment. The guidance suggests a suitable wording for booklets; this explains the various circumstances in which students might be involved in teaching and says 'we hope you will co-operate in this work if we need your help. If, however, you do not wish to take part in any teaching work, it is open to you to refuse without your treatment being affected in any way. In this case you should, as soon as possible, inform the Ward Sister, or the doctor.' The guidance goes on to say 'The distribution of explanatory literature should, however, be regarded as no more than an insurance that a patient has been made aware that the hospital he is to attend is engaged in teaching; it should not be looked upon as an acceptable substitute for personal explanation by the teacher. On the first occasion that a student is present during the examination or treatment of a patient, or himself attends the patient, his status and the reason for his attendance should be explained to the patient whose co-operation should be sought. When practicable, this explanation should be given by the teacher but may be given by the student or a member of the nursing staff. Whenever a teacher proposes to discuss a patient's condition with a student in the presence of the patient, or to demonstrate the condition to a group of students or doctors, he should ensure that the patient understands the situation and consents.'

24. I have seen a copy of the patients' booklet which the AHA said that the complainant's wife would have received. The paragraph on teaching reads:

> 'It is necessary to train staff in all aspects of maternity care in hospital, in clinics and in your own home. Your co-operation is sought and will be greatly appreciated, but if you do not feel able to participate, please discuss this with the Midwife or Doctor.'

25. My officer spoke to the Area Administrator (the AA) the Area Nursing Officer and the Area Medical Officer (the AMO) about this complaint. All three said that they had not been aware of the Department's latest guidance. The AA agreed that the paragraph in the patients' booklet was not in line with it, although he stressed that there was provision for patients to object if they did not want to be involved in teaching. The AMO told my officer that medical students received the same 'standing orders' as junior (that is, below consultant grade) medical staff and that these did not make any reference to teaching. He also explained that it was only in recent years that the AHA had been taking medical students, and that usually students had open access to patients.

26. The consultant who had arranged the student's placement (the first consultant) told my officer that he had not been aware of the Department's guidance. When my officer asked him what guidance he had given to the student about asking patients to consent to her presence, he replied that he had given no guidance about this, although he had been told that she had asked patients if

they minded if she was present. He explained that she did this because it was normal practice in her home teaching hospital.

27. The consultant under whom the complainant's wife was admitted (the second consultant) told my officer that the wife herself had to give consent to the presence of the student; it would not have been acceptable if the complainant had been asked on her behalf.

28. In her evidence to me the student said that she did not remember what had been said about consent to her presence at the birth.

Findings

29. I find it disturbing that the senior officers of an AHA should be so vague about the rights of a patient in relation to participation in teaching when this matter has been the subject not only of departmental guidance but of considerable press and public concern. Indeed I and my predecessors have referred to this matter in a number of our reports. There is no evidence that an explanation was given to the complainant's wife in accordance with the departmental advice (see paragraph 23) and I uphold this part of the complaint.

(e) *The complaint that the SHO concentrated on instructing the student rather than on the complainant and his wife's emotional needs*

30. The complainant said that he and his wife had been in need of some comfort or encouragement from the SHO, but instead he had concentrated on explaining what was happening to the student and had ignored him and his wife. The complainant's wife told my officer that most of the time she had not been aware of what was going on. The complainant said that the only time the SHO had spoken to them was when he told his wife he was 'going to cut now' before he did the episiotomy. The complainant also said that the things the SHO had said to the student about the way to deliver the babies had made him aware of all the problems involved, and that the SHO had seemed to treat his wife like a demonstration dummy. He said he felt that it was very unfair to subject him and his wife to a blow by blow account of what could have turned out to be the life or death of their children. He also said that he had found the birth disturbing and that after it he was emotional and upset, and had had three weeks away from work and many sleepless nights.

31. The AHA made no specific reference to this complaint in their reply to the complainant.

32. The SHO told my officer that it was not his policy to ignore the emotional needs of his patients. He said that in a normal delivery he believed that it was better if the father was present. However, in a complicated delivery, for example twins, when there might be forceps involved, he preferred fathers not to be present unless they were self-confident, and if he had known the complainant was not fully prepared and might be disturbed he would have taken this into account. However, he emphasised that his priorities had been to deliver the twins safely and to care for the complainant's wife and that any special emotional support for the complainant would have had to take second place. The SHO did not recall what he had said to the student.

33. Although the SHO did not remember the delivery itself, he did recall meet-

ing the complainant and his wife the next day. He told my officer that the complainant's wife had been very friendly but the complainant had been 'very cold' and 'most peculiar'. He said he remembered quite clearly that at the time he had mentally reviewed the delivery to try to account for the complainant's attitude which he had thought was strange, since there had been no problems with the delivery and everything had gone well. He said that a few days later he had seen the complainant's wife alone and had said that her husband had not looked well. He said she had replied that her husband had been upset because she had been in pain during the delivery and he had gained the impression from her that until then the complainant had not known what was involved in childbirth.

34. The midwife told my officer that the delivery had been 'one of those nice deliveries where everyone seemed happy' although they were concerned about the babies. She could not remember the student being present or whether the SHO had instructed her, but said if he had given any instructions it would only have been in the form of a running commentary about what was going on. She said she could not remember what he had said to the complainant's wife, but as a rule the SHO was very good and considerate to patients and she had not noticed any difference in his attitude on this occasion.

35. The pupil and the paediatric SHO told my officer that they could not remember what was said during the delivery. In her evidence the student said 'As I recall [the SHO] did not instruct me at any time during the actual births. I do not recall in detail what [he] said to the complainant and his wife but from the impression gained at that time I find it difficult to believe that their needs were ignored'.

Findings

36. I am satisfied that the SHO concentrated on the safe delivery of the twins. He could have no other priority. I do not uphold this complaint.

(f) *The way that the AHA answered the complaint*

37. The complainant wrote to the hospital administrator (the HA) about his complaints and in his letter to the HA the complainant expressed his gratitude to the staff, some of whom he named, for the care given to his wife and children and said that some of his complaints might seem trivial but that 'at times of emotional strain small things can be deeply distressing'. The HA acknowledged receipt of his letter on 20 May 1980 and also asked the second consultant and the SNO (who was acting for the Div NO) for comments. He sent a copy to the General Administrator (the GA) at the AHA's headquarters. The HA received the second consultant's comments on 29 May and the SNO's on 2 June, and these were sent to the GA. The AA replied to the complainant on 17 June and on 23 June the complainant wrote to the AA expanding his complaints and to say that he remained dissatisfied but did not want any further correspondence with the AHA. He thanked the AA for the time and trouble he and his staff had taken on his behalf. He then asked me to investigate.

38. In his letter to me and in his interview with my officer the complainant said the AHA's reply had not satisfied him. He said the answer about cleaning seemed to suggest he was lying, or mistaken, that he did not think that whether the doctor was tired was relevant to his complaint about the examination, and that

some of his complaints had not been answered at all. He said his complaints had not been taken seriously and the AHA had not grasped that he had been concerned about the way women in labour were treated at the hospital, rather than only his wife's experience.

39. The AHA told me that they had attempted to deal with the points the complainant had raised within the time available to them. They said that during the course of their investigations the complainant had twice visited the AHA office pressing for a reply and indicating that he was considering an approach to me.

40. The second consultant told my officer that the complainant had told him he was dissatisfied before he wrote to the AHA, and he had met him and tried to explain the constraints under which the maternity service had to operate. However, as the complainant had evidently remained dissatisfied the second consultant had advised him to write to the AHA. The second consultant said it had been difficult for him to comment first hand on the complaint as he had not been present at the birth. He considered that the AA's reply was a good one; he thought it was right to give the impression that the service was not perfect and that they were trying to improve it. but that medical priorities must come first.

41. The GA told my officer that he had been anxious to send a reply within a reasonable time, as the complainant had called at the AHA office and indicated that he was considering referring his complaint to me. He also said that he had not felt a detailed specific response was appropriate; he had favoured a general reply because he knew from his enquiries that the complainant had been emotionally disturbed by the birth. He said he would have preferred to continue the correspondence locally and had been disappointed that the complainant's second letter precluded this. He said that he had not thought there was a general underlying criticism of the way women were treated in the hospital but that he had made specific complaints about his own and his wife's experience.

42. The AA told my officer that his reply placed emphasis on the aspects which he had thought were important. He said that he had been satisfied with the reply, and that normally if people thought that certain points had not been answered they wrote to the AHA again. He had not thought it would be helpful to offer to meet the complainant who had already had a number of meetings with staff.

Findings

43. The AHA should of course have ensured that their first reply dealt with all the complaints. But this minor fault is not in my view deserving of criticism, particularly as the complainant did not allow the AHA the opportunity to remedy this deficiency.

Conclusion

44. I have given my findings in paragraphs 7, 14, 19, 29, 36 and 43. The AHA have asked me to convey in this report their apologies to the complainant and his wife for the shortcomings I have found and this I gladly do. They have also assured me that they will be undertaking an urgent review of the information given to patients and staff about the teaching of students.

Case No. W.163/80–81 – Inadequate information regarding post-mortem and inquest procedures

Background

1. On 23 January 1980, the complainant's brother, aged 26, died in hospital (the hospital). A post-mortem examination and a Coroner's inquest were necessary.

Complaint and jurisdiction

2. The complaints made by the Member of Parliament (the Member) which had been put to him by the complainant on behalf of his parents related both to the health authority and to the Coroner and I explained to the Member and the complainant that the legislation defining my powers precludes me from investigating the actions of a Coroner or his officers. My investigation was therefore confined to those complaints which were within my jurisdiction, namely that:—

(*a*) the hospital did not give the parents clear and sufficient information about the procedures that would apply in respect of the post-mortem examination, the Coroner's inquest, and the subsequent disposal of their son's body, or help them to deal with these matters;

(*b*) the hospital did not provide adequate information to the Coroner;

(*c*) there was maladministration in the manner in which the hospital dealt with a claim for the replacement of the brother's raincoat which had been lost there in May 1979;

(*d*) the hospital made no arrangements with the parents for the disposal of their son's personal effects; and that

(*e*) the Area Health Authority (the AHA) did not deal with the complaints satisfactorily.

Investigation

3. During the investigation I obtained the written comments of the AHA and examined relevant documents. One of my officers interviewed members of the nursing and administrative staff concerned. She also met the complainant and on a later occasion his parents. The evidence in the opening paragraphs of each section of my report is based on those interviews and the complainant's letters to the AHA and to the Member.

(a) *The complaint about the lack of information and guidance when the complainant's brother died*

4. The complainant's mother said that on 23 January a woman from the hospital had telephoned to inform her that her son had died. The woman told her that as the death had been sudden there would have to be a post mortem and asked her to telephone next day for more information. The complainant's mother asked if she and her husband should go to the hospital but was told there was no need. The father told my officer that his wife had become very upset and that he had taken the telephone from her. The caller repeated to him her regret at the death and explained that his son (who was a 'grand mal' epileptic) had had a severe seizure while having tea and had choked. The following morning,

the complainant's mother said, she telephoned the hospital as requested and spoke to a woman in the administration offices who, so far as she could remember, said that the body had been taken to a nearby town for the post mortem and that all further information would come from the Coroner's office. The mother said that she had assumed that her son's body had been taken to a hospital in that town but had not realised that the Coroner referred to was also there. She said that she was again told there was no need to go to the hospital. Almost immediately after this conversation, she said she received a telephone call from the police in the area in which the hospital is situated. The caller had asked if they were going to the hospital and said further information about her son was needed. She said that they had been told it was not necessary for them to go and the caller had said that he would contact the hospital to sort out the matter.

5. The complainant said that as his parents had heard nothing further on 26 January they engaged an undertaker who made arrangements for the cremation on 31 January. He said that when he arrived home on 27 January his parents were totally confused; they could not tell the undertaker which Coroner was involved, or where the body was. He felt that it should have been made clear to them at the outset that a post mortem was necessary, that there would be a Coroner's inquest and that the Coroner should have been identified. He said that on 28 January he and the undertaker, by enquiring of the hospital and the Coroner's office, had established which Coroner was handling the matter but it was not until 30 January that the undertaker could arrange for his parents to see the body.

6. In reply to the complaint the District Administrator (the DA) explained that, once a death was the subject of a Coroner's inquest and the relatives had been so informed, the hospital was no longer involved in the transmission of information. That became the responsibility of the Coroner and the AHA later wrote to me to confirm this. The DA told the complainant that he was sorry if this was not clearly explained to the complainant's parents at the time.

7. The hospital administrator (the HA) in a report to the DA about the complaint said that in accordance with normal hospital practice the nursing officer who was on duty when the son died (the first NO) informed his parents and next morning (24 January) the medical records department (the MRD) told them of the Coroner's involvement and the need for an inquest. The HA said that that afternoon the complainant had telephoned the MRD to say that neither he nor the undertaker could obtain a reply from the Coroner's office. The HA said that the MRD had also tried but without success.

8. The HA told my officer that when he had taken up his post on 1 January 1980 he had decided to delegate the administrative arrangements following patients' deaths to the MRD and he was certain he had briefed the medical records officer (the MRO) on the procedure before the son died. He said that it was unfortunate that their son's was the first death under the new procedure and that it also involved the Coroner, but he commented that little guidance can be given to relatives in such circumstances as the hospital staff would be unaware of the arrangements being made by the Coroner. The HA was unable to account for the discrepancy between his report (paragraph 7) and the complaint

(paragraph 5) concerning the date on which the complainant had first contacted the hospital.

9. The first NO told my officer that she could remember informing the complainant's mother of her son's death but said she could not recall speaking to the father. She said that she had not mentioned the post mortem or inquest as she thought the necessary explanation would be given later if the mother acted on her suggestion to telephone the hospital during the evening or next day. She had not suggested whom the mother should contact but thought that she would probably speak first to the ward staff who would advise her to talk to the HA. She said she did not know to whom the complainant's mother spoke the next day.

10. The MRO told my officer that when the son died the MRD was not responsible for the administrative arrangements. She thought that the nurse on duty would have contacted the police, and would have asked the next-of-kin to speak to the HA next day. The MRO said she had not been involved until the complainant had telephoned to say he could not contact the Coroner. Although she had not dealt with such matters before, she took the call as the HA was not available and told the complainant that so far as she was aware it was the Coroner's responsibility to inform relatives about the inquest. She said that she also tried to contact the Coroner's office for him but the line had been constantly engaged.

11. The HA's personal assistant, who had also been the previous HA's secretary, told my officer that she could not remember speaking to the complainant's mother but she said that she had spoken to the complainant on one occasion, she thought, after he had unsuccessfully tried to contact the Coroner. On the advice of the nursing officer who was responsible for the son's ward (the second NO) she had advised the complainant that only the Coroner could provide the information he then needed.

Findings

12. I have not been able to establish to whom the complainant's mother spoke on 24 January or to resolve the conflict between the evidence of the HA and that of the MRO (paragraphs 8 and 10) as to where the responsibility for giving advice then lay. I accept that the hospital lacked detailed information about the inquest, the release of the body to the undertaker, and the issue of the death certificate, all of which were the responsibility of the Coroner, but they should have advised the mother about the role of the Coroner in general terms and given her his address. Individual members of staff seem to have done what they could to help but they lacked clear instructions. I uphold this complaint.

(b) *The complaint that the hospital did not provide adequate information to the Coroner*

13. The complainant said that when he had asked the Coroner's officer why his parents had not been given the information I refer to in paragraph 12 he was told that the details given to the Coroner by the hospital had not included the next-of-kin. He also said that the Coroner's officer had expressed surprise as to where the undertaker concerned was based as their information indicated that the firm concerned was elsewhere.

14. The DA told the complainant that the Coroner had been provided with all the necessary information by the police who had visited the ward the day after the son's death and he said he felt sure that details of the next-of-kin would have been included. He said he could throw no light on why the Coroner thought an undertaker from elsewhere was involved. The AHA informed me that the body was removed from the hospital shortly after the son's death on 23 January to a District General Hospital where a post mortem was performed the following day.

15. The HA told my officer that he thought that the police had visited the hospital on behalf of the Coroner on 24 January and had recorded the son's details including his next-of-kin. He said that the telephone call from the police to the mother (paragraph 4) would probably have come from the local police acting on a request from the Coroner's office. The HA's personal assistant told my officer that she was certain the Coroner's office had not contacted the hospital's administration department for any further information.

16. The nursing notes, which I have examined, show that the police visited the ward on the evening of the son's death and that the charge nurse made the following entry: 'Body was examined by PC . . . at 21.05 hrs'. A second entry was made by the night staff: 'PC . . . and CID members arrived at 10.30 pm to see deceased and collect further information. Undertaker arrived to take son's body at 10.45 pm'. The charge nurse told my officer that all the information required by the police was available in the medical record to which they had access. The information sheet at the beginning of the record, which I have seen, includes the names and address of the deceased's parents as his next-of-kin.

17. The Coroner for the area told me that the correct details of the next-of-kin are recorded on the file.

Findings

18. Although the statements of the HA and the DA are at variance with the nursing notes as to when the police, acting on behalf of the Coroner, visited the hospital I am satisfied that the police were aware of the next-of-kin whom they telephoned on 24 January. I do not uphold this complaint.

(c) *The complaint about the claim for the replacement of the raincoat*

19. The complainant said that it had been admitted that the son's gaberdine raincoat had been lost in the hospital in May 1979 and that in June an attempt had been made to fit him with a replacement from the hospital's clothing store. This was not successful and the second NO advised his parents that financial reimbursement would be considered within three weeks but when they approached him later he said that a replacement would be supplied. After repeated reminders the clothing store manager (the CM) promised the coat by Christmas but it still had not been issued when the son died. Some weeks later the mother telephoned the CM who said that the order had been cancelled and referred her to the second NO who promised reimbursement but the complainant told the HA on 25 February that it had not by then been received.

20. The second NO in a statement to the AHA said that when the coat could not be found in May 1979 the charge nurse had carried out a search of wards,

departments, and the laundry and then reported that it was missing. He said that having discussed the matter, he and the senior nursing officer (the SNO) approached the CM who assured them he could supply a replacement. The second NO had arranged for the son to be measured and the CM had said he anticipated that he could obtain the coat within a month. The second NO said that the mother's frequent enquiries during the following months, which he found embarrassing as it appeared that no action was being taken, were referred to the CM who in mid-January had undertaken to contact the manufacturer and in the meantime a lightweight mackintosh was made available. The second NO stated that on 11 February 1980 the mother had telephoned him to request compensation as she understood that the order for a replacement had been cancelled. In interviews with my officer the second NO and the SNO confirmed that they had seen the CM in June 1979 to arrange for the issue of a replacement which they regarded as an *ex gratia* payment in kind. The SNO said that he thought it had been resolved that a coat would be purchased and the second NO showed my officer a copy of a clothing requisition which he had authorised on 29 June 1979, the reason recorded thereon as 'Replacement Jacket'.

21. The CM said in a statement to the AHA that the second NO told the mother at the unsuccessful fitting in June 1979 that the matter would be referred to the finance department to arrange reimbursement. The CM said that he was not consulted again until the autumn when the second NO had asked him to find a supplier for a replacement as reimbursement had not been made. He had indicated that it would be difficult to find a manufacturer prepared to accept a single order for an outsize coat and that he had confirmed with the then HA that the replacement of private clothing required the authority of the District Management Team. He said that the coat was eventually ordered on 3 October 1979, delivery being promised in about 6 weeks, but at the time of the son's death it had still not been delivered; he told my officer that he had no record of the requisition of 29 June 1979.

22. In his reply of 19 May 1980 to this complaint the DA said that from his enquiries it appeared that too many assumptions had been made about who was responsible for action when the raincoat first went missing. He said that a new coat had been ordered on 3 October 1979 but in the event the manufacturers could not promise the CM a delivery date. The DA apologised to the complainant for the loss of the coat and for the protracted inconvenience to his parents and said that he had reported the matter to the District Management Team who had recommended an *ex gratia* payment of £50. He said that he was sending a cheque for this amount to the parents together with a letter of apology.

Findings

23. The nursing and clothing managers were clearly at cross-purposes due to the lack of a proper procedure and as a result the mother was inconvenienced and inadequately informed. I uphold this complaint but I am pleased to see that the AHA took action within a reasonable time of the matter having been brought to their notice.

(d) *The complaint about the disposal of the personal effects*

24. The complainant said that the hospital made no attempt to arrange for

the disposal of the personal effects and the mother confirmed to my officer that the subject was not discussed until she herself raised it when she telephoned the hospital some weeks after her son's death about her claim for the replacement of his raincoat (paragraph 19).

25. The AHA told me they accepted that no arrangements were made with the parents in respect of his personal effects. In normal circumstances relatives were given these when they attended the hospital to collect the death certificate but because this was a Coroner's case the certificate was not completed there. The AHA also told me that such cases were very rare at the hospital and that therefore the staff were unfamiliar with the problems that could arise.

26. The nursing staff interviewed by my officer explained that normally personal effects would be dealt with on the day after a patient's death. After the appropriate records had been made, valuables would be taken to the general office and the HA would contact the relatives about them. The second NO told my officer that there was, however, no clear policy on clothing and the ward staff said that as they knew the subject could be distressing they tended to wait for the relatives to contact them. The second NO further told my officer that it was not normal practice to return dirty clothing to relatives and some of the son's clothes would probably have been sent to the laundry and then to the clothing store if there had been no other arrangements with the relatives. I have seen from the relevant record that the son's clothing was sent to the clothing store on 3 March. The charge nurse told my officer that the clothing the son was wearing at the time of his death would have been retained by the police.

Findings

27. The AHA have admitted that no arrangements were made with the parents for the disposal of the personal effects. It is quite wrong to place the onus on relatives in these circumstances and I uphold this complaint.

(e) *The handling of the complaint*

28. The complainant's first letter of complaint of 4 February which dealt with the matters considered in sections (*a*) and (*b*) above, was acknowledged by the HA on 6 February. The DA in his full reply of 29 February said that he was sorry that the parents had been left in such uncertainty and regretted if anything done or said by the hospital staff had hindered the complainant's enquiries of the Coroner. He concluded with an offer of further help.

29. The complainant's second letter of complaint, which is dealt with in sections (*c*) and (*d*) above, was sent on 25 February and also included references to missing underclothing. It was acknowledged on 3 March and on 10 March the complainant was asked for further information about the underclothing and he replied on 17 March. On 19 May the DA replied to the complaints and offered to meet the complainant to discuss them further if he wished. The complainant told my officer that in view of the time taken he thought an interim reply should have been sent.

30. The complainant wrote to the Member on 28 April to say that the DA's reply to his first letter did little more than offer sympathy and merely sought to deflect responsibility for possible maladministration on to 'sister authorities'

and that there had at that time been no reply to his second letter. He told my officer that there was no indication that the administration accepted that their procedures required review.

31. The AHA told me that a sub-committee, consisting of an AHA member, the Area Medical Officer and the Area Nursing Officer, which had been established to look into complaints, had considered reports, copies of which I have seen, on the way in which the complaint was being handled. The AHA said that the sub-committee had found no reason to suggest that alternative action should have been considered.

32. The DA told my officer that he recalled examining the complaints with his senior administrative assistant and deciding in some detail how to reply. He said he did not think he could have explained the situation more fully in his letters and having apologised and invited the complainant to talk over the matter with him he said he did not know what else he could have done.

33. The DA and the HA both acknowledged to my officer that there was a delay between 25 February and 19 May and that an interim reply should have been sent and I have seen that the investigation was protracted by enquiries into the further complaint about the underwear. The DA told my officer that the request for compensation had to be submitted to the District Management Team and my officer established that they had met on 13 May and agreed the payment of compensation.

Findings

34. The AHA investigated the complaints adequately and have acknowledged that an interim reply should have been sent to the complainant. Of more importance however is their failure to indicate to him that the hospital's procedures required review or that remedial action was being taken and to this extent I uphold this complaint.

Conclusion

35. I have given my findings in paragraphs 12, 18, 23, 27 and 34. I have found evidence of administrative confusion caused by an absence of clear procedures and effective communication. The AHA have assured me that steps have been taken to remedy this. The AHA have also asked me to convey in this report their apologies for the shortcomings I have found and for any distress that may have been caused, and I gladly do so.

Case No. W.171/80–81 – Refusal to reimburse patient for cost of prescription

Background and complaint

1. The complainant attended a hospital (the hospital) during the evening of 23 August 1979, suffering from a recurrence of abdominal pain for which she had previously received treatment there. She was seen by the duty Senior House Officer in Obstretrics and Gynaecology (the SHO) who gave her two alternative prescriptions, one for the hospital pharmacy (the hospital prescription) and the other to be dispensed by an outside chemist (the second prescription). The complainant used the second prescription but had to pay £22.59 for the drugs. Subsequently she sought reimbursement of the additional cost of the second

prescription but the Area Health Authority (Teaching) (the AHA) refused to make any payment. She complained to me about the AHA's refusal.

Investigation

2. During the investigation I obtained the written comments of the AHA and examined the relevant documents on their files including the complainant's clinical notes. One of my officers met the complainant and members of staff involved in the complaint. She spoke to an officer of the Department of Health and Social Security (the Department), whose file of correspondence on the case I have also seen.

3. In correspondence with the Department and the AHA in 1979 and 1980 the complainant gave the following account of events. She said that on 23 August 1979 she needed some antibiotics because of abdominal pain caused by an illness for which she had been receiving treatment at the hospital until May 1979. In July 1979 she had been notified by her local Family Practitioner Committee (the FPC) that her family practitioner was retiring at the end of July. Because she was a student taking examinations at the time she did not register with another doctor at once; consequently when her illness recurred she was without a family practitioner. She telephoned a local doctor who agreed to accept her as his patient but told her that in the circumstances she should attend the hospital where she had been treated previously.

4. The complainant said that at 7 pm on Thursday 23 August she was seen by the SHO in the gynaecology out-patients' department. Her clinical notes were not immediately available and because the SHO was due in the operating theatre she examined the complainant without waiting for them. The SHO gave her the two prescriptions and said she could choose which to use but added that the hospital pharmacy was open only from 9 am – 5 pm, Monday to Friday. Since the pharmacy was closed at the time of the consultation she had the choice of either returning to the hospital the following day, which involved a difficult and indirect journey by public transport, or going to a chemist's shop. Because she was working temporarily in a place directly accessible by public transport and was due to finish the following morning a job she had been working on for two weeks, the complainant decided to go to work and have the second prescription dispensed by a local chemist (the chemist). The SHO had told her to rest and she felt that what she proposed to do would be less tiring than going back to the hospital.

5. The complainant took the prescription to the chemist at lunch time when the shop was busy. When she returned at 5.30 pm to collect it she was told that the prescription was a private one and that she had to pay £22.59 which represented the cost of the antibiotics and the dispensing fee. The complainant felt she had no option but to pay because the hospital pharmacy was closed by that time and would not open again until the following Tuesday, the Monday being a Bank Holiday.

6. The complainant pointed out in her letters that she was a National Health Service patient, that she had not been asked whether she wanted to be treated privately and that, although at the time it appeared that she was being helpful by giving a choice of prescriptions the SHO did not say that the second one

was private. In the circumstances the complainant did not think she should be expected to pay for drugs to which she was entitled under the National Health Service and she asked for reimbursement of the cost. She made the point that as a student dependent on a grant, she would not willingly pay £22.59 for something she was entitled to get for 40p.

7. The Department replied to the complainant's first letter on the basis of information provided by the AHA that the SHO had stated that she told the complainant she would have to pay the full cost if she used the private prescription; the AHA did not therefore feel able to make a refund. She wrote again expressing dissatisfaction with this reply since it ignored her main point that she should not be asked to pay the full cost when she was being treated as an NHS patient. The Department referred her letter to the AHA. The District Administrator (the DA) replied to her that he understood from the SHO that the complainant had mentioned some difficulty about returning to the hospital the following day and the SHO had therefore given her a private prescription on hospital notepaper, explaining that if she used it she would have to pay for the drugs. The DA added that, having been assured that the cost implications were explained to her he was unable to reimburse the cost she had incurred. In further correspondence the DA said that the SHO remembered the complainant saying it was difficult to return the next day and therefore, in order to assist her, she gave the second prescription. The SHO was adamant that she stressed that it was private. The DA said he had no reason to doubt her recollection of events and was unable to reimburse the complainant.

8. In discussion with my officer the complainant said that while she was dressing and the SHO was writing a prescription, she asked when the pharmacy was open. The SHO said that the normal hours were 9 am until, as far as the complainant could remember, 5 pm but added that because the following Monday was a Bank Holiday it would be closed then. The complainant mentioned that it would be difficult for her to return to the hospital and the SHO said she would give her another prescription which she could take anywhere. At no time, she said, did the SHO mention that she would have to pay for it or say that it was private. The complainant thought the SHO was being very helpful and was surprised the following day when she was asked to pay; she told my officer she had not insisted that she could not return to the hospital and had not asked for the second prescription.

9. In the correspondence between the Department and the AHA the DA stated that the hospital pharmacy was open from 9 am – 6 pm Monday to Friday and from 9 am – 12 noon on Saturday. A pharmacist was also available from 4 pm–6 pm on Saturday and from 11 am–12 noon on Sunday. In forwarding the complainant's second letter to the AHA the Department said they understood that NHS out-patient prescription forms, FP10(HP), were issued to hospitals for just such cases as this and, if one had been available, no problem might have arisen. They suggested that the AHA might reconsider the request for reimbursement. In reply the DA said that forms FP10(HP) were kept under lock and key to prevent abuse and because drugs cost considerably more when dispensed by an outside chemist. I have noted, however, that the consultant had previously made it clear that these forms were not available in the gynaecology out-patients' department.

10. I have seen the Department's circular issued in 1976 to health authorities, giving guidance on the use of forms FP10(HP). It says that their use may be authorised where a hospital has no dispensary of its own and it has not been possible to make regular and convenient arrangements for dispensing out-patients' prescriptions at another hospital, or where hospital pharmacies have had to restrict the services provided for out-patients due to shortages of staff. Authorities are reminded of the importance on economic grounds of keeping to a minimum the use of these forms in authorised circumstances. A member of the Department's staff assured my officer that the guidance was intended to allow the use of FP10(HP)s during all closures of a hospital pharmacy, including routine closure at night.

11. In their written comments the AHA told me that there was no written procedure for the prescribing of drugs to casual attenders at the Obstetric and Gynaecology Department of the hospital when the pharmacy was closed, although they were considering the issue of such guidance. The practice was to prescribe medication for collection from the pharmacy when it was next open, although if a doctor considered that a patient required drugs more urgently a small quantity for use until the pharmacy reopened was given from a stock in the Labour Ward. Forms FP10(HP) were not issued and private prescriptions were only issued when patients *insisted* that it was inconvenient to return to the hospital and they preferred to visit a chemist's shop and pay for their drugs.

12. The SHO told my officer that she remembered the complainant asking her about hospital pharmacy opening hours and saying that it would be awkward to return the next day. The SHO said that she told the complainant to rest at home and try to get someone else to collect her drugs; but she also offered her a prescription which could be made up by a chemist, telling her that she would have to pay for the drugs. She said that had she been asked what the charge was likely to be, she would not have been able to answer. The SHO has since left the hospital and could not remember the pharmacy opening hours, but she was aware that it was open on Saturday mornings; she said she knew the exact opening times when she worked at the hospital. Initially she told the complainant the opening hours for the following day, but, when the complainant said this was difficult, she would have told her the Saturday hours. She would not have looked any further ahead because she wanted her to start the course of drugs as soon as possible. Although the complainant was more pressing than most about the difficulty in returning the following day, the SHO said that the patient had not insisted that she could not go back. I have seen the SHO's record of the consultation in the clinical notes but it makes no reference to any discussion about prescriptions.

13. The District Pharmaceutical Officer (the DPO) told my officer that forms FP10(HP) had been misused in the past; consequently although some forms were kept in the hospital they were locked away. He said that apart from the problem of misuse, drugs prescribed on these forms and dispensed by chemists cost about 28 per cent more than those dispensed by the hospital pharmacy. The DPO added that hospital medical staff were not told on appointment that the forms were available because they already received so much information they could not take in any more. If a doctor wanted drugs for a patient when the pharmacy was closed there were three options available to him; he could obtain supplies

from a ward in an emergency, or obtain access to the pharmacy where 200 – 300 of the most widely used drugs were readily available, or telephone the on-call pharmacist who would attend if necessary or give advice over the telephone. Moreover, since this complaint – though not as a result of it – some pre-packaged drugs were available in the Obstetric and Gynaecology Department.

14. The DPO said they knew that some patients had difficulty with transport and in this particular case he thought that the SHO was trying to help the complainant by giving her two prescriptions when she mentioned such difficulties. He did not think that transport difficulties generally were serious enough to warrant changing the system because, if a serious problem had existed, there would have been more complaints. He added that the complainant's situation was exceptional because it was usual for a patient to see the family practitioner who would either prescribe drugs to be dispensed by a chemist or refer the patient to the hospital in the normal way.

15. In discussion with my officer the DA said that he preferred the SHO's account of the consultation because she was consistent in what she said despite being questioned by several members of staff. He thought that the complainant's account contained inconsistencies because she said she was a student without much money yet she went to work the day after her hospital visit. He also felt that since she was able to attend the hospital in the evening she should have been able to return the next day, especially if she was able to go to work; he did not think that the difficulty of the journey was sufficient reason for not returning to the hospital pharmacy. The DA and the DPO were surprised that the complainant was not registered with a family practitioner because it was normal for the patients of a retiring doctor to be re-registered automatically. The DA said that when he received the letter from the Department asking him to reconsider the case for reimbursement he did so, but he still accepted the SHO's account of events and therefore saw no reason to make a payment to the complainant.

16. In written comments and in discussion with my officer the Administrator of the FPC confirmed that the complainant's former family practitioner retired on 31 July 1979; because the FP had a small list it was decided not to appoint a successor but to disperse her patients among other local practitioners. On 18 July the complainant was notified in writing of her family practitioner's withdrawal from the medical list of the FPC with effect from 31 July and was invited to register with another doctor. The Administrator said that when a list was dispersed it was normal to ask patients to re-register themselves rather than to allocate them to another list.

Findings and conclusions

17. I have found that NHS out-patient prescription forms FP10(HP) are available to area health authorities for use in hospitals in certain limited circumstances. The Department have assured me that the use of these forms is authorised whenever a hospital pharmacy is closed, although I do not think that that is altogether clear from the terms of the Department's guidance (paragraph 10). However, the AHA have not argued that this case fell outside the limited circumstances for the use of these forms; they have said that they do not make the forms available within the hospital for reasons of economy and because of misuse in the past. Nonetheless it seems to me that there may be occasions when

the use of such a form is entirely appropriate and I have noted that the Department informed the AHA that this was just such a case (paragraph 9). I endorse that view.

18. The AHA have told me (paragraph 11) that private prescriptions are *only* issued when patients *insist* that it is inconvenient to return and they prefer to visit a chemist's shop and pay for their drugs. In this case both the complainant and the SHO have said that the former did not insist but said that it would be difficult for her to return to the hospital; indeed, had she insisted, there would have been no point in issuing the hospital prescription. As to what the complainant was told about the second prescription there is a direct conflict of evidence which I cannot resolve, but I am quite satisfied on the basis of the evidence I have seen that she did not say that she preferred to visit a chemist's shop and pay for the drugs. I find, therefore, that the AHA's criteria for the issue of a private prescription were not met. And I do not accept the DA's view that there were inconsistencies in what the complainant said.

19. In the light of my findings I invited the AHA to review their decision not to make a payment to the complainant to cover the extra cost of the second prescription. I am pleased to record that they have agreed to reimburse her. They have also asked me to convey to her their apologies for the inconvenience she has suffered and this I gladly do. I regard this as a satisfactory outcome to my investigation.

Case No. W.215/80–81 – Failure to carry out requested post mortem on stillborn baby

Complaint and background

1. On 4 June 1980 the complainant, who was in her 36th week of pregnancy, was referred urgently to hospital (the hospital) by her family practitioner. Hospital staff informed the complainant that they, also, were unable to detect foetal heartbeat and after an induction a stillborn child was delivered the following day. The complainant gave his permission for a post-mortem examination (the PM) and he also said he wished the hospital to arrange for the burial or cremation of the baby and handed the necessary papers to the hospital administration office on 6 June.

2. On 8 July at an out-patient consultation the complainants learned incidentally that the hospital had disposed of the child's body before the PM was carried out and they complained to me:

(*a*) of the hospital's failure to carry out the PM; and

(*b*) that the Area Health Authority (the AHA) failed to explain the error satisfactorily.

Investigation

3. During the investigation I obtained the written comments of the AHA and one of my officers interviewed members of the administrative, mortuary and portering staff concerned. He also spoke to the consultant pathologist who would have been responsible for carrying out the PM.

(a) *The complaint about the failure to carry out the PM*

4. The complainants said that during the evening of 5 June, after the stillbirth, the husband was asked by the medical staff if he would consent to the PM, which he readily did as he and his wife were anxious that every effort should be made to identify the cause of death in view of her obstetric history. He was also asked whether he intended to make arrangements for the disposal of the body himself, or whether he wished the hospital to do so. He said he wished the hospital to make the necessary arrangements to avoid further emotional distress. He was told that following registration of the stillbirth any papers handed to him by the Registrar of Births, Marriages and Deaths (the Registrar) should be passed on to the administration office at the hospital to enable the body to be disposed of at the appropriate time. He registered the stillbirth on 6 June and received from the Registrar a sealed envelope which he delivered personally to the hospital administration office that afternoon.

5. The wife's family practitioner arranged for her to see a consultant gynaecologist and obstretrician at the hospital on 8 July. The husband also attended so that they could both be told of the results of the PM and other tests and, in the light of those results, discuss with the consultant the prospects for the success of a future pregnancy. It was at this consultation that they first learned that the baby's body had been disposed of by the hospital before the PM and that therefore the information which they hoped to obtain would not be forthcoming.

6. In their replies to the husband and to me the AHA explained that after he gave his permission for the PM the appropriate forms were authorised by the Sector Administrator (the SA) on 6 June in the absence on holiday of the Unit Administrator (the UA). The papers were then passed to the pathology department and the PM was arranged for 10 June. Unfortunately on 9 June the mortuary technician (the technician) injured his foot and as he was therefore unable to assist at the PM, it was postponed until 12 June. But when on 12 June the technician went to collect the body from the mortuary he found that it had been removed the previous day.

7. The AHA said that the disposal certificate issued by the Registrar and received from the husband on 6 June was processed in the normal way by a higher clerical officer (the HCO) in the hospital's general office who was unaware that a PM had been authorised and who made routine arrangements with a local funeral director for the disposal of the body, which was collected on 11 June. The AHA said that the head porter had specific instructions not to release bodies from the mortuary without prior approval from the UA. This procedure was not followed on 11 June by the relief porter who was on duty in the mortuary because the head porter was on sick leave and his designated deputy was on night duty. The AHA said that in the absence of the UA two other members of the administrative staff had been involved, neither of whom was aware of the other's actions.

8. The SA told my officer that he was to blame for much of what had happened; the system for the disposal of bodies had at that time revolved entirely around the UA. He said that he covered for him when he was away but sometimes a situation arose in which he did not know exactly what action the UA normally took, and he had authorised the PM without telling the HCO. He

was based at another hospital in the district and when the UA was away he visited the hospital at least once a day but he was not there when the husband brought the disposal certificate. He had not known that anything had gone wrong until the complainants made their complaint. The SA said that in October 1980 a new mortuary had been opened which was under the full-time supervision of the technician and that comprehensive written operational policies (which I have seen) had been introduced which should obviate any similar mistake in the future.

9. The HCO told my officer that when she received the disposal certificate from the husband on 6 June she did not know that a PM was involved. She had assumed that the SA would have told her if it was, and she made the normal arrangements for disposal with a local funeral director who collected the certificate from her before going to the mortuary. The UA told my officer that had he been present the disposal certificate would have been retained by him and not given to the HCO until he was satisfied that the PM had been carried out.

10. The head porter confirmed to my officer that he was on sick leave at the relevant time, and that as his deputy was not available when the funeral director came to collect the body on 11 June any one of 15 porters could have released the baby's body. Although none would do so without a disposal certificate he was not sure how many were aware of the extra safeguard of checking with an administrator. The general porter concerned told my officer he could not recall the particular case but said he would never release a body without a certificate. The technician told my officer that when he went to the mortuary to collect the body on 12 June he found that it had already been taken away and he immediately reported the fact to the pathologist.

11. The pathologist confirmed to my officer that he was told on 12 June that the body had been collected but that as nothing could then have been done it was not reported. He said that at that time the system for the disposal of bodies was not well organised but he said that the new arrangements (see paragraph 8) for the supervision of the mortuary were much more satisfactory.

Findings

12. Due to the particular circumstances outlined in paragraphs 6–11 but more importantly to the absence of clearly written and promulgated procedures at the time, a serious failure occurred. I uphold this complaint and am relieved to note that positive steps have been taken to prevent a recurrence.

(b) *The AHA's explanation of the error*

13. When on 8 July the complainants realised that the information they had hoped to gain from the PM was not available the husband wrote to the UA requesting, within ten days, 'a fully detailed explanation'. The UA acknowledged this letter on 10 July and, as he had had no reply, the husband sent a reminder on 21 July. On 23 July the District Administrator of the AHA's northern district (the DA) replied. He regretted the delay, which he explained was due to the need to obtain information from several members of staff, and went on to explain what had happened (see paragraphs 6 and 7 above). He apologised to

the husband for this and he said that he appreciated that an apology seemed inadequate in view of the additional distress that had been caused to him and his wife. On 4 August the husband wrote seeking clarification of a date in the DA's letter and on 8 August the DA replied, and the husband wrote again on 18 August. When they wrote to me, the complainants said the DA's reply was far from satisfactory; they criticised his 'bland use of jargon' and described his phraseology as 'frivolous to the point of being objectionable'.

14. The DA told my officer that he had regarded this complaint very seriously and that he had therefore dealt with it personally. Although he usually offered to meet complainants who were dissatisfied he did not so do in this case as the facts were not in dispute and a full explanation and apology had been given.

Findings

15. In his replies the DA gave relevant facts, honest explanations and an unreserved apology. He wrote sympathetically and, in my view, not objectionably. I do not uphold this aspect of the complaint.

Conclusion

16. I have given my findings in paragraphs 12 and 15 of my report. I well understand the concern and dissatisfaction felt by the complainants which must have been accentuated by the AHA's further failure in not informing them promptly of the error made. A lesson has obviously been learned and I hope that the complainants will gain some reassurance from this. The AHA have asked me to record in my report their repeated apologies for the distress caused to the complainants and I gladly do so.

Case No. W.218/80–81 – Conditions and poor communication with patients in Accident and Emergency Department

Background and complaint

1. The complainant's mother, aged 77, was referred to a hospital (the hospital) by her family practitioner on 16 April 1980 suffering severe pain in the right subscapular region which was accompanied by violent vomiting. She was taken there by ambulance and according to the complainant arrived at 9.40 pm. The complainant followed by car. The complainant alleged through her Member of Parliament that:—

(*a*) although the staff were supposedly expecting her mother she had to wait over four hours for treatment and discharge;

(*b*) the examination cubicle occupied by her mother lacked privacy and there were no pillows;

(*c*) the Accident and Emergency Department (the A and E Department) was generally dirty and decrepit and the vending machine for refreshment was not in working order;

(*d*) the nursing staff in the A and E Department were unhelpful, miserable and totally unconcerned for the comfort or well-being of the patient; and

(*e*) the response by the Area Health Authority (the AHA) to the complaints was unsatisfactory.

Investigation

2. During the investigation I obtained the comments of the AHA and saw the relevant correspondence. My officers discussed the complaints with members of the medical, nursing, administrative and ancillary staff concerned and took evidence from the Ambulance Service; my officers also met the complainant, her mother and sister.

(a) *Delay in getting treatment*

3. The complainant said she first thought that her mother was to be taken to another hospital but the ambulance men said that they were going to the hospital. She telephoned the family practitioner who had made the arrangements and he confirmed the destination; the complainant recalled that he said that he had spoken to the 'Matron' of the hospital and that her mother was expected and would be admitted. The complainant thought that in these circumstances her mother would have a brief examination immediately on arrival prior to her admission. In the event however she said that her mother was not taken for x-rays until after midnight and that at that stage she had not been examined by a doctor. Eventually, the complainant thought about an hour after the x-rays, she went to the doctor's room and asked whether or not he was proposing to treat her mother. She believed that but for her intervention, they might have waited even longer. She said she could not be certain whether the doctor had been in the A and E Department all the time her mother was there but her mother and sister remembered that the doctor had been 'running from patient to patient' because he had been so busy. The complainant remarked upon the kindness of the doctor and his care and she recalled that he said he would arrange for her mother to have a painkilling injection and if the reaction was satisfactory she would be allowed to go home. This was the case. She, her mother and her sister independently told my officer that they arrived home between 1 and 2 am.

4. The records held by the Ambulance Service suggest that the family practitioner specifically requested the ambulance to take the complainant's mother to the hospital. In written evidence the family practitioner said he telephoned the casualty officer on duty there in advance of her arrival. But the hospital Patients' Services Officer explained that although all referrals by family practitioners should be routinely and separately recorded she could find no record of any referral for the complainant's mother. The Nursing Officer now responsible for the A and E Department (the NO) made the point that a family practitioner referral did not necessarily mean that a patient would be seen out of turn; the complainant would anyway have had to be seen by the casualty officer on duty and it was for the sister on duty in the A and E Department to assess priority and so to determine the order in which the casualty officer examined patients. The sister in charge of the Department on 16 April (the sister) confirmed this arrangement and said that the symptoms of the complainant's mother did not prompt her to give the patient high priority.

5. My officer spoke to all four nurses on duty in the Department on 16 April – the sister, a staff nurse, a state enrolled nurse and a student nurse. Two of them recalled the period as a busy one and I have seen from the register that 34 patients arrived in the Department between 7 pm and 10.30 pm that night. The sister said that two casualty officers were on duty on weekdays until 9 pm but that after

that time there was one; there was often a backlog of patients by this time because the two casualty officers worked a 12 hour day and delays built up when one of them took a meal break. She said the casualty officer on duty when the complainant's mother arrived was very conscientious and thorough and this tended to add to the delays. The casualty officer could not recall the complainant but confirmed that backlogs did occur when he took over and sometimes they took three to four hours to clear; he never took a meal break himself while on duty between 9 pm and 9 am. He confirmed that he might occasionally send a patient for x-rays prior to an examination if he was busy.

6. The A and E Department register for 16 April records the complainant's mother's arrival at 9.50 pm. It also shows that of the 15 patients who arrived before her between 8.30 pm and 9.50 pm eight were '999' cases. The x-ray examination is documented but no times are kept for such examinations. The NO thought the average night time wait for a case of the complainant's mother's type was between two and four hours and the sister said two hours. The sister remembered the complainant's mother being given an injection at about 12.30 am and thought that she left not long afterwards.

Findings

7. I do not doubt that the family practitioner telephoned the hospital but the evidence does not support the complainant's belief that he intended that her mother should go to another hospital. I accept that when patients arrive in the A and E Department they have to take their turn in order of medical priority. That is a matter for the clinical judgment of the sister on duty and I do not question it. I find that it was not reasonable for the complainant to expect that her mother should have been examined immediately merely because the family practitioner had telephoned the hospital. But in my opinion a wait of three to four hours was far too long. From the evidence I have obtained in this and another similar case which I have investigated, I have seen that such delays are not exceptional. In this and the earlier case the delay arose primarily from the fact that only one member of the medical staff was on duty. In the course of the earlier investigation I was informed that the casualty officers' duty roster was being reviewed and I am pleased to record that changes to it have twice been made in 1981. When the complainant discussed her complaint with my officers she expressed concern that the Administrator offered little evidence of attempting to introduce improvements but in the light of this additional information I do not think that this charge still stands.

(b) *The examination cubicle*

8. The complainant said that on arrival her mother was put on a hard trolley with one blanket over her and without a pillow. When she saw my officer the complainant's mother vividly recalled her discomfort and particularly the hard canvas surface of the trolley. The complainant said the trolley was wheeled into a narrow, dirty cubicle which had torn, filthy and ill-fitting curtains partly dividing it from the neighbouring cubicle; the curtains did not extend the full length or height and a torn dirty screen had been put up to add to the general squalor. Because the curtaining did not fit properly, the complainant and her mother were able to see and be seen by the patient in the next cubicle who had been involved in a road accident and by members of her family. The complainant

said that there was a complete lack of privacy and her mother had to use a bedpan in full view of those in the adjoining cubicle. When a nurse took her mother's blood pressure the patient was asked to take off her dressing gown and the nurse left the concertina doors at the front of the cubicle open, thus exposing the patient to even more of those attending the A and E Department that night. The nurse retorted that it did not matter as they were all in hospital and when the complainant closed the doors the nurse complained that it was too hot.

9. The sister explained that the cubicle used by the complainant's mother and the neighbouring one were created by dividing a former waiting room. She found them unsatisfactory as there were no windows in either, they were usually hot and airless and conversations could not be private; she did not use them unless she had to but this was the case on the evening of 16 April. Prior to the complainant's mother's attendance one of the curtains had had to be removed because it had been covered with vomit and because there were no spare curtains a screen had had to be used which she thought was just as effective. She and her nursing colleagues confirmed that pillows were always in short supply. She accepted that when a patient was sitting on a bedpan on a trolley he or she might be visible to those in the adjoining cubicle. The NO explained that it was normal nursing practice to have the concertina doors open so that staff could observe patients. The nurses could not specifically remember any difficulty when the patient's blood pressure was taken but the Divisional Nursing Officer pointed out that taking blood pressure was a routine which did not require privacy on the ward and curtains were not drawn when doing it.

Findings

10. Sufficient pillows were not available and the AHA have apologised for this. I do not criticise the staff for leaving the concertina doors open and the complainant should I think accept that there can be no objection to a patient's blood pressure being taken in view of other patients. It is not in any way an embarrassing procedure. But that does not excuse the inadequate screening between the two cubicles. I am pleased to report that the NO told my officers that there is now sufficient curtaining (including a spare) to divide fully the two cubicles. But a conscious decision has been made to retain those two cubicles so that they might be combined if particular circumstances required the larger area. I am satisfied that the disadvantages of the cubicles are known to the nursing staff and that they are used only when the number of patients attending the Department or the particular circumstances require it.

(c) *The Department's appearance and the vending machine*

11. The complainant said that the A and E Department was generally dirty and decrepit. One difficulty she brought to my particular attention was that the vending machine for refreshments had broken down. When she asked the sister for a drink of water for her mother during their wait she was told that there were no facilities for giving patients drinks. She said a porter subsequently provided a drink on hearing of the problems which he fetched from his own quarters.

12. Very soon after the complaint was referred to me one of my officers visited the A and E Department. The impression he gained was one of a dirty, shabby building in need of decoration and some refurbishing. None of the staff contested

the complainant's description of the Department's decoration although some referred also to the manner in which the public abused the facilities. The NO explained that at the time of the complaint cleaning of the A and E Department was carried out in the mornings and again at midnight; the complainant would therefore have seen the Department at its worst when she arrived.

13. As regards the request for a drink, the staff nurse recalled being asked for one by the patient's relatives but felt that her reply had been misunderstood. The complainant's mother had been vomiting and until the doctor had examined her and sufficient time had elapsed after the injection was given, it would not have been right for the patient to have had a drink. The sister confirmed this. Both the staff nurse and sister expressed surprise that the porter should have given the complainant a drink for her mother because the portering staff were trained not to give drinks without first asking the nurses. The porter on duty in the Department at the time could not remember getting the complainant's mother a drink but he added that this was something he frequently did, since the vending machines were often out of order. He said however he always checked first with the nursing staff that a patient's medical condition allowed it.

14. The District Catering Manager said that there were constant problems with the vending machines due largely to vandalism; my officer saw his records which confirmed that there were many occasions when the machines in the A and E Department were out of order. The Catering Manager explained that between 9 am and 5 pm alternative facilities were available to the Department's patients but that the vending machines were all that was available outside these hours.

Findings

15. I am in no doubt that the complainant's impressions of the Department were correct. I am therefore pleased to record that the majority of the Department has already been re-decorated and that the remainder will be done quite soon. Furthermore the arrangements for cleaning the Department have been revised in the light of this and other complaints about the state of the Department with the intention of providing an improved cleaning service there. But it has to be recognised that some members of the public using the Department do not treat it with respect. There is no drinking fountain in the Department but water and glasses are available in all the cubicles other than the one used by the complainant's mother and its neighbour. Again the evidence is that the vending machines are misused by the public and that there is no maladministration by the hospital in this connection.

(d) *Nursing staff attitudes*

16. The complainant said that the nursing staff in the Department were unhelpful, miserable and totally unconcerned to such an extent that she had to assist other patients who obviously needed attention. She said that after the nurse had taken her mother's blood pressure she told them that she would be attended to but did not say how soon. When the complainant requested pillows she was told merely that there were none. On another occasion she asked the sister for a bedpan for her mother and the sister handed her one and left her to cope on her own with her mother.

17. The complainant's mother said that she did not remember any nurse speaking to her except when she was given a painkilling injection. Her sister too remembered no conversations although she had not been present all the time in the Department.

18. The sister did not remember any particular approach from the complainant, but she recalled having a long chat with her mother about arranging further treatment. She thought that the patient was quite happy and found her a nice pleasant lady. She did not accept the allegations against her and her staff; she said their work was governed entirely by the medical staff and with the limited number of staff available they expected relatives to provide comfort and sympathy, leaving the nurses to provide treatment for all and to care for people who had no relatives with them. She felt that the complainant should not have concerned herself with other patients but should have reported both their and her own problems to her at the time. The staff nurse remembered speaking to the complainant about refreshment (paragraph 13) but the other three nurses could not otherwise remember any conversation with the family. The state enrolled nurse said that it was a busy evening and she did not have time to think about other patients with whom she was not dealing or to have a word with them.

19. The Divisional Nursing Officer with overall responsibility for the A and E Department said that he had been concerned about the communication that the night staff had with patients and, equally, about the problems the nursing staff faced. He felt that patients received nursing care in the Department but it was a service 'without frills' and there was room for improvement. He said that he was making every effort to encourage staff to communicate with patients and this was now an important aspect of student nurse training. He added too that he had now introduced a rotation system so that nursing staff no longer worked permanently on night duty in the Department. And although the four nurses on duty on 16 April was the staff complement at the time, this had subsequently been increased to a minimum of five.

Findings

20. The complainant's feelings about the nursing staff are subjective and I can make no absolute judgment. But clearly the Divisional Nursing Officer was not wholly satisfied with staff attitudes. I think the complainant's opinions stem primarily from lack of communication since I have no reason to doubt that she and her mother were given insufficient explanation about the delay. I accept that the Department was busy but I do not think that that should prevent the staff from explaining matters to waiting patients, not in itself a time-consuming action. Even if the staff on 16 April had insufficient time to approach the complainant and her mother solely to reassure them, there were clearly a number of occasions when they had this opportunity but did not use them. The AHA have told me recently that the question of communication between patients and relatives on the one hand and medical and nursing staff on the other, continues to concern the District Management Team and because of this concern, a meeting has been held with senior members of the medical and nursing staff in the Accident and Emergency Department to consider ways to improve the situation. In addition to reviewing generally the working of the Department, it was decided to place arrangements for monitoring the activities of the Department on a more formal

basis. A meeting will be held quarterly to review current complaints, to check progress in rectifying already identified shortcomings and to try to detect at an early stage if there are particular patterns emerging in the substance of complaints.

(e) *The unsatisfactory response by the AHA*

21. The complainant wrote to the hospital on 18 April, two days after the episode setting out her experiences and copying her letter to her Member of Parliament. The Sector Administrator sent a substantive reply to her on 27August and when the District Administrator sent a copy of the reply to the Member, he drew attention to the pressures with which the Department had to cope– although he stressed that he was not making excuses – and invited the Member to visit the Department. The Member acknowledged the pressures but said that he was nevertheless referring the case to me because, among other things, he felt it would help to draw the conditions at the hospital to the attention of senior officials in the Department of Health and Social Security as well as Ministers. The complainant said that she herself remained dissatisfied with the reply because it was prevaricating and made excuses for the unsatisfactory situation without showing any positive moves towards improvement.

Findings

22. It was unfortunate that the Sector Administrator's reply was delayed – she explained that this was because the complainant's medical records were initially mislaid – but, that apart, I see no reason to criticise the thorough and sympathetic reply which apologised frankly for the admitted shortcomings. I do not think it was unduly complacent but I hope that the complainant will accept that the hospital have taken steps to make improvements since this unfortunate episode. I do not uphold this aspect of the complaint.

Conclusions

23. The AHA have not denied that the complainant's mother was in the A and E Department for more than three hours. The fact that only one casualty officer was on duty caused this. The complaint was similar to another I investigated involving delay in the same Department in April 1979. No additional medical staff have been appointed in the interval but I know that the need for additional staff has been, and continues to be, recognised. I must conclude that the unimproved position has not resulted from maladministration by the health authority but arises essentially from financial constraints and the need to assess priorities between competing demands for additional medical posts. This is not a matter which I am empowered to question. The duty roster for the existing complement of casualty officers is a separate issue and changes to it have twice been made since the episode which is the subject of complaint. In the responsible consultant's view the present roster is the one best suited to cope with the most likely pattern of attendance at the A and E Department. It allows for improved cover for a longer period of the day. Delays in busy periods cannot be avoided. I understand that it has now been agreed to appoint an additional Senior Registrar. I hope that when he takes up post, these delays will be reduced.

24. The AHA have not disputed that conditions in the cubicle the complainant's mother occupied and in the Department generally were as the

complainant described them. In the earlier case I investigated, the Member was also critical of conditions in the Department but did not pursue these with me when the District Administrator told him on 1 June 1979 that improvements were being made. I have now been assured that the Department has been decorated and that there are shorter intervals between the occasions it is cleaned. I fully recognise though that the AHA have a difficult problem here in having to deal with the ill-mannered and abusive way certain members of the public conduct themselves in a public place provided to assist those requiring emergency treatment.

25. As for the attitude of the nursing staff I have concluded, as I did in the earlier case, that communication with the patient was not all that it should have been. In the earlier case the AHA agreed (after the events of this one had taken place) to remind staff of the importance I attached to communication with the patient and I sincerely hope that I do not receive any more complaints on that score. The complainant was fully justified in bringing her experiences to notice and in the main I have upheld her complaints. I hope that after reading this report that she will get some consolation from the fact that the AHA have taken action on many aspects of them.

Case No. W.342/80–81 – Loss of dentures after admission to hospital

Complaint and background

1. The complainant's 75-year-old aunt was admitted from a nursing home (the first nursing home) to hospital (the hospital) on 3 July 1980. On 2 August she was discharged to a second nursing home. The complainant said that his aunt's dentures were lost or mislaid soon after her admission to the hospital and that they had not been replaced.

Investigation

2. During the investigation I obtained written comments from the Area Health Authority (the AHA) and saw their papers. One of my officers spoke to hospital staff concerned and corresponded with the complainant and with the former proprietor of the first nursing home.

3. The complainant wrote to the hospital on 26 July 1980 indicating that his aunt was likely to be discharged on 2 August but that her dentures appeared to be missing. He added that he had mentioned the apparent loss to the ward charge nurse several times, the first being two days after his aunt's admission, and had been told that the dentures were probably in her locker. He said that he and the first nursing home could confirm that his aunt had them on admission to the hospital but that the nursing staff at the hospital had been unable to accept this because the dentures were not recorded on the Clothing and Property Card on which all property was listed when a patient was admitted. He said that if all belongings were listed on the Card he wondered why his aunt's spectacles and rings did not appear on it. He also took exception to a comment by one of the nursing staff that 'people try this to obtain new dentures' and he concluded his letter by asking the hospital to authorise the preparation of a new set for his aunt.

4. In the course of the enquiries that were made by the hospital, the Senior Nursing Officer (the SNO) confirmed that the ward charge nurse was sure that

the complainant's wife did not have dentures on admission. He said that on admission the patient had been unable to give any information about her circumstances and was using a different surname which caused confusion. The SNO said that the charge nurse had explained to the complainant that patients occasionally neglected to bring dentures into hospital and that this forced the hospital to supply new dentures; but this was not an insinuation that this patient was fraudulently attempting to obtain a new set of teeth.

5. On 11 September the Patients' Services Officer (the PSO) made telephone calls to both nursing homes. The note of the conversation with the first recorded that the staff there could not be 'one hundred per cent sure that [the complainant's aunt] had dentures in her mouth when she left'. The matron at the second nursing home informed the PSO that in view of the aunt's condition they were not proposing to arrange for new dentures for her.

6. On 1 October the Sector Administrator at the hospital (the SA) replied to the complainant assuring him that as far as all the nursing staff were aware his aunt did not have her dentures with her on arrival at the hospital although he accepted that it was possible that she lost them without the knowledge of the nursing staff. The SA also explained what the nurse had intended when making the remark to which the complainant took exception. He added that no unclaimed dentures had been found on the ward since the aunt's departure and he regretted that he could not be of more assistance.

7. When the complainant wrote to me he contended that if the dentures were lost while his aunt was in the hospital it was their responsibility to replace them. He said that his mother, his aunt's sister, saw his aunt leave the first nursing home and that he had accompanied his mother to the hospital the same evening when they visited his aunt. He said that his aunt then had her dentures but two days later when they next visited, the dentures were missing. He said he asked the charge nurse about them on that occasion and on his next three visits but was told only that patients put them down somewhere. The complainant said he searched his aunt's belongings twice but did not find the dentures. He told me that new dentures had not been obtained pending the outcome of my enquiries and because of his aunt's condition.

8. When the AHA responded to the complaint the Area Administrator (the AA) said that it was not their policy to accept responsibility unless property was handed in for safe-keeping and a receipt given, although property as personal as dentures would normally remain in the charge of the patient but be listed. He added that a Clothing and Property Card was used to record all items which a patient brought into hospital and that it was stated on the Card which the patient was normally asked to sign, that the hospital were not responsible for the loss of any item not deposited for safe-keeping. He said that the dentures had not been listed because all the nursing staff said that the complainant's aunt did not have dentures on admission. He maintained that the Authority could not reasonably accept responsibility for the loss of dentures in these circumstances.

9. I have seen the aunt's Clothing and Property Card and noted that it did not list the dentures. But I have also seen that additional items – spectacles and rings – have been added to the list in different handwriting although they were

not included in the copy of the list the complainant saw and sent me. In internal correspondence the SA had already noted this and had said that he did not wish to over-estimate the usefulness of the Card and it was quite conceivable that there was an omission in entering the dentures. The SNO told my officer that he had reminded nursing staff of the need to sign additions to Property Cards. The PSO added that the Property Card had been revised recently so that one of the headings now read 'Cash and valuables (including dentures)'. Finally I noted that the Card does contain a denial of liability for items not deposited for safe-keeping.

10. The former proprietor of the first nursing home said in a letter to me that his wife remembered that on transfer the complainant's aunt was in possession of her dentures because there had been a telephone enquiry from a relative about the dentures some three weeks after the transfer. The proprietor said that at that time the staff nurse who discharged the complainant's aunt had been perfectly clear that she was wearing her dentures; he added that this fact was recalled because it was a peculiarity of hers to hide her dentures in odd places and the staff quickly learned to check their whereabouts. The proprietor had no record or recollection of a telephone call about the dentures on 11 September.

Findings and conclusions

11. Based on evidence from the nursing staff, the first nursing home, the Clothing and Property Card and the absence of unclaimed dentures on the ward, the AHA felt unable to accept responsibility for the loss of the patient's dentures believing that she did not have them with her on admission to the hospital. In my opinion, however, the record of the telephone call to the nursing home was equivocal and the evidence of the Clothing and Property Card suspect; I also find it surprising that the nursing staff have never denied that they told the complainant that the dentures were probably in his aunt's locker or had been put down somewhere. In all these circumstances I have serious doubts whether the AHA's decision not to accept responsibility for the loss was soundly based. And I am confirmed in my view by the evidence I obtained from the former proprietor of the first nursing home.

12. In the case of a confused patient, which the complainant's aunt clearly was, I accept the complainant's contention that a health authority has some responsibility for the safe-keeping of belongings which are of such a personal nature that they have to remain with a patient. However I have obtained independent evidence from the matron of the second nursing home that the aunt's condition was such that she would not have been able to co-operate in the preparation of a new set of dentures. In those circumstances I do not think it was reasonable of the complainant to expect the health authority to make arrangements for their replacement at that time. When his aunt's condition improved the complainant apparently decided to await the outcome of my enquiries before deciding whether he should take any steps in getting the dentures replaced. I do not think that that was a reasonable course if he thought they needed to be replaced urgently. On the balance of probability I believe the dentures were lost soon after the aunt's admission to the hospital but since the relatives took no steps to replace them in the nine month interval between the AHA's denial of responsibility and the aunt's death I think that no more than the AHA's apologies to the complainant are called for. I am pleased to record

that the AHA have agreed that I should convey their apologies to the complainant and this I gladly do. I am also pleased to record the steps taken by the hospital to improve their procedures (paragraph 9) which I regard as a practical benefit arising from this complaint. I would also offer my condolences to the complainant on the recent death of his aunt.

Case No. W.387/80–81 – Charge for dental treatment and handling of complaint by Family Practitioner Committee

Background and complaint

1. The Member of Parliament (the Member) at the request of his constituents (Mr and Mrs A) complained to me that when Mrs A had received dental treatment from a local dentist she had been charged as a private patient whereas she had understood that the treatment was provided under the National Health Service (NHS). The Member had previously corresponded with the Family Practitioner Committee (the FPC) and he was dissatisfied with the way they had dealt with the complaint.

2. I explained to the Member that under the legislation which defines my powers action taken by dentists in connection with the services they provide under contract with FPCs is outside my jurisdiction. I could not therefore investigate the arrangements made between Mrs A and the dentist for dental treatment if it had been provided under the National Health Service; nor had I jurisdiction in respect of any private arrangement made between the dentist and his patient. I agreed however that I would investigate the way in which the FPC handled his complaint on Mr and Mrs A's behalf from the administrative viewpoint, and the information about the consultation is included only to put this in its context.

Investigation

3. During the investigation I obtained copies of the FPC's relevant papers and also received information from the Department of Health and Social Security (the Department). My officer interviewed Mr and Mrs A, the FPC Administrator (the administrator) and also the dentist.

4. Mrs A had been suffering from toothache and she had gone without an appointment to see the dentist on Saturday morning, 31 August 1979. He had fitted her in between appointments and gave her the treatment that she wanted. She then went to his reception office where she was told that the treatment would cost £4. Mrs A said that she pointed out to the receptionist that she was not required to pay this as her husband was on supplementary benefit. She said that the receptionist told her that she would have to pay but that she should take the receipt to the local Social Security Office (the local office) and that she would have the money refunded. Mrs A paid the £4 and received a receipt.

5. Mr A told my officer that the next day he wrote to the local office but did not get a reply and he therefore wrote again on 19 September, by recorded delivery. I have inspected the certificate of posting. Mr A said that they heard nothing more from the local office until February 1980 and there was no reference to the repayment of the charge made when they did hear. As a consequence of a discussion with a friend Mrs A went to see the Member on 14 June 1980.

6. The dentist told my officer that Mrs. A's case involved an ordinary emergency casual extraction. He said that he knew it was provided under private arrangements as a different procedure would have been followed had it been an NHS case. He knew nothing of the complaint until he received a letter which he thought came from the Member but he had a later one from the administrator. He explained that where there was any dissatisfaction it was his policy to try to sort it out personally but in this case Mrs A had not been to him about it; he had felt inhibited from making any approach to her for fear of it being misconstrued. The receptionist had left the dentist's employ and her present whereabouts were not known but the dentist told my officer that she was a dental receptionist of considerable experience.

7. The Member wrote on 17 June to the manager of the local office saying that he had been approached by Mrs A about the payment of the £4 and that she had written to the Department but she had heard nothing. The manager of the local office (the manager) replied that an application for exemption from the payment of dental charges by Mrs A had been processed on the 7 February and that she had been given a notice confirming that she was not liable for NHS charges. He explained that where a person was not liable but had already made a payment under the NHS a refund was made by the FPC. The manager had contacted the FPC who told him that the treatment on 31 August was arranged as private treatment and therefore a refund could not be made. After telling Mr and Mrs A about this correspondence the Member again wrote to the manager who replied that he had passed the Member's letter to the health authority for action.

8. The administrator wrote to the Member on 9 July saying that he had received the letter from the manager and stating –

> 'Under (NHS) arrangements the onus is on the patient to ensure that they receive (NHS) treatment. On the first occasion when they visit a dentist they should inform him immediately that they want NHS treatment and every time they start a new course of treatment they should also ensure that the dentist has accepted them for (NHS) treatment.
>
> It would seem from Mr A's letter that the dentist was approached asking for treatment for the aching tooth, this was extracted but no (NHS) form was completed and the dentist has confirmed by telephone that treatment was given under private arrangements.
>
> Under these circumstances my Committee are not able to refund the charge made for this private treatment and I can only suggest that on future occasions when Mr or Mrs A approach a dentist they ensure that they are receiving (NHS) treatment.
>
> In this connection I enclose herewith leaflet NHS4/Nov 78 which explains the procedure for obtaining (NHS) dental treatment . . .'

The Member replied on 15 July that he found this reply completely inadequate. He asked what contact the administrator had had with Mrs A about the complaint.

9. The administrator replied on 18 July and after dealing with the statutory arrangements for dental treatment said: 'In the case of Mrs [A] there is no evidence to support the contention that she was accepted as [an NHS] patient

and indeed a check of the payment schedules for the dentist in question has not revealed the submission of a Dental Estimate form to the Dental Estimates Board for payment.' He added that he had had no direct contact with either Mr or Mrs A and that there was nothing to suggest that in Mrs A's case she had specifically asked for the treatment to be given under the NHS. He also said that the treatment about which Mr A was complaining was apparently given to his wife on 31 August 1979 and: 'If this is so the present correspondence is well outside the time limits for making complaints in accordance with the National Health Service (Service Committees and Tribunal) Regulations 1974, as amended', – (the Regulations) – 'which in the case of dental treatment should be within six months after completion of the treatment, or within eight weeks after the matter which gave rise to the complaint came to the Complainant's notice, whichever is the sooner'. He ended by saying that he could only repeat his advice that should Mr and Mrs A require any further dental treatment they should take care to ensure that they have been accepted by the dentist for treatment under the NHS.

10. The Member replied on 23 July saying that he had supplied the administrator with considerable evidence about Mrs A's complaint but that nothing had been done to investigate it. He said that he was not interested in whether it fell within the Regulations; as a Member of Parliament he had referred the case to the administrator for investigation and he expected him, as a public servant, to investigate it; he looked forward to receiving a full report of his investigation and the conclusion.

11. The administrator's reply of 31 July to this letter was that he treated every enquiry or complaint in exactly the same way irrespective of whether it came from an ordinary member of the public or a Member of Parliament but that he could not treat as a complaint any matter which on the information available appeared to relate to treatment provided outside the NHS. He went on 'If Mr [A] can produce positive proof that the emergency extraction of his wife's tooth was carried out under [NHS] arrangements I will be happy to look into the matter. Otherwise, as you well know, private treatment is outside my jurisdiction. Finally, may I say that I resent being called 'a public servant'. As an employee of the Health Service I try to do my duty to both the public and professions conscientiously and completely impartially but I have never been nor will I ever be anyones servant'. The Member's answer of 12 August to this was that if he referred a complaint which he received from a constituent to the administrator he expected that he would investigate it thoroughly and that he had been advised by the Secretary of State for Social Services (the Secretary of State) that a thorough investigation should take place; but it seemed that the administrator's investigation had been limited to contacting the dentist by telephone. The Member concluded 'You are paid from public funds, as I am, and consequently you are a public servant, as I am. The sooner you realise this the better'.

12. The administrator replied to the Member on 26 August that the dentist had confirmed in writing that he had seen Mrs A on 31 August 1979 for emergency treatment which was carried out under a private arrangement for a fee of £4 and consequently an NHS receipt had not been issued. The Member replied on 1 September that he had noted that the administrator had received a

statement from the dentist but said that an investigation involved listening to both sides and he asked him to say whether he intended to contact Mrs A. The administrator in a reply of 3 September wished 'first of all (to) correct the mistaken impression . . . that I have 'investigated' this matter'. He had asked the dentist to say whether or not Mrs A had been accepted as an NHS patient. The administrator went on to draw the Member's attention to the Regulations.

13. On 29 September 1980 the Member told the administrator that Mr A first wrote to the local office on 1 September 1979. He said that he was advised that the appropriate Service Committee of the FPC could investigate complaints made out of time if they were satisfied that failure to make a complaint within the time was caused by illness or other reasonable cause. He said that he was further advised that a complaint could be made by or with the authority of the person entitled to the service concerned, and asked: 'Are you suggesting that a Member of Parliament cannot make such a complaint on behalf of a constituent'?

14. The administrator's reply to this dated 2 October confirmed that the Regulations did allow an investigation out of time if the Service Committee was duly satisfied. He went on to say that the Regulations required the complaint to be made in writing, and ' this is stated on page 2 of the patient's medical card and also on leaflet NHS 4', but that the fact that a letter of complaint had been misdirected to the Member would not preclude the Dental Service Committee (the DSC) from looking into the complaints provided there was no undue delay in writing to the Committee once the correct position was known. He added that the Regulations stated that a complaint should be made by the person entitled to the provision of general dental services or with the authority of that person; but in this case the person entitled to the provision of the service was Mrs A and nowhere in the correspondence was there any authority from Mrs A for either her husband or for the Member to act on her behalf. The Member then told the administrator that he had referred the correspondence to the Secretary of State.

15. The Joint Parliamentary Under Secretary of State told the Member that the complaints procedure could operate *only* where it had been established that a patient had been accepted for NHS treatment and that in this instance there was no evidence that Mrs A was accepted for NHS treatment and the dentist had made no claim for payment from NHS funds. He said that he had a good deal of sympathy with patients who may be left in doubt about the nature of the contract and that they could do no more than give publicity in their leaflets and otherwise to the legal position, which is that the onus lies on the patient rather than on the dentist to establish acceptance under the NHS on each occasion of treatment. He said that there was a further avenue of complaints open to aggrieved patients, under the wider scope of the General Dental Council which is responsible for matters concerning professional conduct of dentists. He pointed out that some time ago the Council had issued a notice (and he included an extract from it) to all registered dentists advising them that they had an ethical obligation to make clear to the patient the nature of the contract before starting treatment, although it remained advisable for the patient to check in the first place. He said that he was concerned that the Member found

the letters from the administrator unhelpful, but he had to confirm what the administrator had said about the general legal position.

16. The Member took up the matter with the General Dental Council and I have seen that on 5 May 1981 he asked the Secretary of State if he would seek to place the onus on NHS practitioners to advise patients whether or not they are receiving treatment under the NHS rather than the onus being on the patient as at present. The Minister for Health said that the ethical onus was already on the practitioner and after a short exchange the Minister for Health undertook to look into the matter again with the General Dental Council and the British Dental Association, and I understand that he subsequently wrote to the Member.

17. The Department told me that an examination of the records at the local office had shown no evidence of the receipt for £4 which Mr A said was sent on 1 September nor was there any trace of a letter sent by recorded delivery on 19 September 1979. They had received on 6 February a claim form in respect of Mrs A's dental treatment and this was dealt with on 7 February 1980. I told the Department of the information I had obtained regarding Mr A's correspondence with them and gave them the details of the recorded delivery certificate. They made enquiries of the local office and advised me that although a further search had been made for the recorded delivery letter it could not be traced, nor was there any evidence of its receipt. On making enquiries of the Post Office, the local sorting office superintendent advised them that although their records are normally retained for two years, there was no trace of the documents covering the relevant period.

18. My officer discussed with the administrator the correspondence which I have reproduced in detail in paragraphs 8 to 14 above and the actions he had taken on behalf of the FPC in respect of the complaint. The Regulations govern the way the FPC deal with formal complaints but there is also an informal procedure for complaints against family doctors and a conciliation procedure for dental cases in respect of the provision of dentures. The administrator said that as the informal procedure did not apply to dentists there was no occasion to use it, or be guided by the spirit of it, and the dental conciliation procedure was inappropriate.

19. The administrator said that he had not dealt with the matter as a formal complaint because he was quite satisfied there was not a valid complaint; it was both out of time and not made by the complainant herself. He had made sure that the treatment had not been provided under the NHS and had checked that there had been no payment made in respect of it; and therefore the NHS complaints procedure was inappropriate as the service provided was not provided under the NHS. He accepted that many people, even well-educated people, were confused by the difference in the way that services were provided by family practitioners and by general dental practitioners. When a person was registered with a doctor for NHS treatment and care the arrangement was a continuing one, whereas every separate episode of treatment with a dentist had to be separately negotiated and agreed. He said that letters reminding dentists of this were sent out when financial statements were sent to them and the local dental committee was always stressing it to dentists and he understood the General Dental Council did so too. It was explained in the training programmes

for dental receptionists but they tended to be young girls and were not always sure what they should do.

20. He was not sure whether he had spoken personally to the dentist about this complaint but he had written to him and received the reply which he passed on to the Member. He told my officer that he had not thought of discussing this complaint with the dentist in an informal way. He said that it was quite common for telephone enquiries to be made to his office about dental matters but they were usually resolved there and then. The administrator was asked, arising from his letter of 31 July, what positive proof might have been expected. He said that he did not really know but that a receipt could have been provided. It was pointed out to him that the receipt was a receipt for private treatment and therefore would not have been eligible for consideration and in any case it had been sent to the local office. The administrator said that he had not known that.

21. When asked what might have happened if the complaint had been referred to the Dental Service Committee, the administrator said that if he had submitted the complaint to the Chairman the latter would probably have decided that there was no case to answer. But *if* the complaint had been put to the DSC, the administrator felt that on the evidence the dentist could not have been found in breach of the terms and conditions of his contract. It was possible that when the FPC themselves considered the DSC's report, they might have felt that there had been a complete misunderstanding and that they might, in submitting the report of the DSC to the Secretary of State, have themselves suggested that reimbursement be made under the extra-statutory powers of the Secretary of State. But any such action would be wholly at the Secretary of State's discretion.

22. The administrator told my officer that he had not told the Member that there was the possibility of considering a complaint out of time because it was so far out of time, and in any case he had not known about the approach to the local office immediately after the incident. He said that the right to make a complaint rested with the complainant or anyone acting with his written authority. The administrator said that he personally did not always accept complaints from a spouse as there were often differences in families and he had had experience of a spouse complaining and the partner denying that he or she wanted to complain. He said he would never accept a complaint from a Member of Parliament without written authority unless the Member of Parliament indicated, as he usually did, that he was writing on behalf of his constituent. He said that on this occasion the Member had been writing on behalf of Mr A and when my officer pointed out that it was Mrs A who had approached the Member the administrator said that he had not known that.

23. The administrator was also asked about the provision in the Regulations that someone could act on behalf of a patient who was incapable of making a complaint by reason of old age or some other disability. The administrator said that he had no indication that Mrs A was not capable of acting for herself. When it was suggested that there was no evidence to the contrary either, the administrator indicated that he felt that the onus to make this point was upon the complainant.

24. The administrator was also asked about his letter of 2 October which referred to leaflet NHS4/Nov 78 and he was asked how he knew whether Mrs A

had had a copy. He said that he could not know and that he thought they were distributed to dentists by the Department. There was no way in which he could be sure that she had had a copy. Efforts were made through Women's Institutes and similar organisations to distribute supplies, and when meeting such bodies he emphasised the differences between being treated by a doctor and by a dentist.

25. The administrator was asked about the Member's reference to him as a public servant and he was adamant that he was not a public servant: he was a public official and he was no-one's servant. He said that he served but that was totally different from being a servant and in his view the term itself had a derogatory meaning. He said that he had a full commitment and would try to do his duty to the best of his ability but he strongly resented the implication of subservience in the word 'servant'.

Findings and conclusions

26. I have seldom come across more inept handling of a perfectly proper complaint to an FPC. I do not at all subscribe to the administrator's view that a Member of Parliament should be treated like anyone else either in theory or in practice: as the elected representative of a substantial section of the community he is entitled to be respected accordingly. The administrator's wooden pre-occupation with rules and regulations was matched only by his extraordinary rejection of the honourable title of public servant. His narrow and unhelpful attitude to the Member's difficulties, exemplified by his emphasis on those regulations which were an obstacle and his omission to mention those which might have helped, was quite deplorable. It may seem ludicrous that so much time and effort should have been expended over £4. But it is important to investigate bureaucratic insensitivity over small matters lest it be allowed to develop and spread into more serious ones. I asked the FPC if they would request the Secretary of State to exercise his statutory powers to award an *ex gratia* payment on the basis that there was here a genuine misunderstanding between the dentist and Mrs A, and if they wanted me to convey to the Member, through the medium of this report, their apology for the annoyance and inconvenience he suffered. They told me that they did not feel that the action taken called for any apology nor were they prepared to make application to the Secretary of State for approval to an extra-statutory payment. They went on to say that 'any annoyance or inconvenience which the Member of Parliament suffered was due solely to his own intransigent attitude'. After a careful investigation I have found the opposite to be the truth. I can only express my deep regret that the FPC will not now do what they can to put right what has been done wrong.

Case No. W.534/80–81 – Handling of complaints by Family Practitioner Committee

Background and complaint

1. On 10 October 1980 the complainant collected new bifocal spectacles from her optician but she was not satisfied with them and returned to him on four occasions between 17 October and 25 November. On 11 December she sought the advice of her local Citizens' Advice Bureau (the CAB) who suggested that she complain about her unsatisfactory spectacles to the Family Practitioner

Committee (the FPC), which she did, but she received neither an acknowledgment nor a reply.

Jurisdiction

2. The complaint that the FPC failed to act and of the hardship the complainant suffered as a result came to me initially through the CAB and it was explained to them and to the complainant that I am not empowered to investigate the actions of opticians in connection with the services they provide under contract with FPCs, but that I would investigate the way the FPC had handled her complaint.

Investigation

3. During the investigation I obtained the comments of the FPC and I examined these and relevant documents from their files. My officers discussed the complaint with the FPC administrator (the administrator). My officer also met a representative of the CAB (CAB organiser) and the complainant and her husband, and she discussed the complaint with the then secretary of the local Community Health Council (the CHC secretary).

4. In correspondence and when she met my officer the complainant said that she found her new spectacles unsatisfactory from the start. On two occasions when she returned to the optician he carried out frame adjustments, and then her sight was re-tested and the optician assured her that the lenses were correct. He told her that her sight had improved slightly and that she must continue to persevere with the spectacles, and he made an appointment to see her again in six months.

5. The complainant told my officer that as she was unable to indulge in her pastimes of reading and needlework she decided to seek the help of the CAB and, acting on their advice, she complained to the FPC. I have seen that she wrote to the FPC on 13 December and related the story of the return visits to the optician, complained that her spectacles were still unsatisfactory and asked where she could have a 'second opinion to prove dissatisfaction'.

6. The CAB organiser told my officer that the complainant first called at a CAB office on 11 December and an interviewer there telephoned the FPC whose advice was that the complainant should write to them direct. On 15 January she called at the CAB office and said that she had written but had heard nothing further and so they telephoned the administrator who confirmed that he had received her letter and promised to deal with it. The complainant called at the CAB office on 19 February and on 26 February and on each occasion they telephoned the FPC. The administrator was out both times but a message was left for him.

7. On 20 February the CAB organiser wrote to the administrator telling him of the complainant's continuing distress with the spectacles and asking him to look urgently into the complaint. She told my officer that she received neither an acknowledgment nor a reply to this letter. The CAB organiser also contacted the CHC secretary on 20 February and explained the complainant's problem to him. She later learned from him that he had contacted the administrator who had told him that the case would be dealt with at a meeting on 11 March. The CAB

organiser said that when the complainant called to see her on 19 March and reported that she had still heard nothing from the FPC she decided to seek my help.

8. The CHC secretary told my officer that he had learned of the complaint from the CAB and that he had spoken to the administrator on two occasions about the complaint. I have seen a note he made of the first of these conversations. He said that the administrator admitted that the lack of action was his fault and told him that he had been unable to deal with the matter because of pressure of work but that it was his intention to put the matter 'to some sort of medical service committee meeting' coming up shortly and the CHC secretary recorded this and informed the CAB organiser. He next heard of this matter when the complainant telephoned him (I have seen that this was on 19 March) saying that she had still not heard from the FPC about her complaint. He telephoned the administrator again but he found him to be 'non-committal' about the matter although he did give a fairly firm assurance that he would deal with it very soon.

9. The administrator told me that the lengthy delay in dealing with the complainant's letter was due to great pressure of work coupled with some difficulty in deciding how to resolve it. He told my officer that the complaint was not an appropriate one to be dealt with by the Ophthalmic Service Committee (the OSC) as there was no allegation that the optician was in breach of his terms of service, and he had instead taken it upon himself to reply to the complainant. However, he could not decide how to answer the letter and put it to one side and 'tried to ignore the complaint in the hope that it would go away'. He added that it was an oversight that no acknowledgment had been sent to the complainant. The administrator told my officer that he did not think there was any solution to the problem. The complainant had had her eyes re-tested to establish that the prescription was correct and in the circumstances he did not think that a third test, even if carried out by a different optician, would have produced a different result.

10. The administrator said he had no recollection of speaking to or receiving telephone messages from the CAB. However, he confirmed that he did receive the letter from the CAB organiser (paragraph 7) but did not reply to this. He could not remember the CHC secretary discussing the complaint with him or telling him that the matter was to be dealt with at a meeting on 11 March (he assured my officer that there was no meeting of the FPC or OSC scheduled on or about this date at which the matter could have been dealt with) and he said that he had had no intention of referring the complaint to the OSC.

[11. The complainant told my officer that eventually she consulted another optician who prescribed different lenses and fitted them to her existing frames. As she had to pay the statutory charge for the second pair of lenses the CAB, at her request, contacted the first optician who agreed to refund to her the charges paid in respect of the first pair of lenses.]

Findings

12. I uphold this complaint. I consider it inexcusable that the administrator chose to ignore the complainant's request for advice or assistance and I regard it as even more serious a failure in view of the number of reminders he had. The

FPC have asked me to convey to the complainant their apologies for this serious administrative failure and this I gladly do. The FPC have also told me that they will apologise to the CAB for the discourtesy to them.

Case No. SW.19/80–81 – Delay in carrying out eye operation

Background and complaint

1. The complainers' seven-year-old daughter, who suffers from hereditary cataract, was admitted to hospital (the hospital) for an eye operation on 10 February 1980 but had to be sent home the following day because she had a cold. A later admission date of 2 March was cancelled by the hospital, causing her considerable distress. When her father enquired about this he was first informed that a machine had broken down and then that there was a shortage of necessary drugs.

2. He complained to the relevant district (the district) of the Health Board (the Board) of the delay and as a result his daughter's admission, which had been further rearranged for 16 March was cancelled and he was told that her treatment would be postponed until the complaint had been settled. He was subsequently informed that the consultant ophthalmologist concerned (the consultant) had decided to withdraw from the case. He also complains of the further delay this caused before his daughter eventually had her operation elsewhere.

Jurisdiction

3. The complainers had also indicated their dissatisfaction that doctors had earlier been disinclined to operate for clinical reasons on their daughter and her twin brother but I explained to the MP involved that I had no power to investigate a decision taken by a doctor solely in the exercise of his clinical judgment and that my investigation would have to be limited to the delays experienced and the cancellation of the operation on the complainers' daughter at the hospital once the clinical decision on the need to perform the operation had been taken.

Investigation

4. In the course of my investigation I have corresponded with the Board and have examined relevant documents from their files including the case notes. One of my officers has interviewed the consultant and pharmaceutical and administrative staff involved and he has also met the complainers.

5. In correspondence and at their interview with my officer the complainers explained that both their children had been attending eye clinics for a number of years, but that it was not until the autumn of 1979 that the consultant agreed to put their daughter on the operation waiting list.

6. She was admitted to the hospital on 10 February, but was sent home the following day because she had a cold. Her parents then received notification that she was to be readmitted on 2 March but they subsequently received a letter dated 27 February from a secretary in the ophthalmic unit (the ophthalmic secretary) informing them that this admission date was no longer possible and apologising for any inconvenience this may have caused. The father said that

he then telephoned the ophthalmic secretary who told him that the cancellation was because a machine had broken down. When the father told her that he was not satisfied with this answer she suggested that he should telephone the following day when he could speak to the consultant. When he did so the consultant told him that the cancellation was because of the non-availability of a drug. The father said that he told the consultant that he was not happy with the situation as his daughter had had her hopes of having the operation built up and then dashed. He told my officer that the delay had distressed his daughter very much and it was because of this that he had complained to the Board.

7. On 5 March the father met by appointment the district administrator (the DA) and the district medical officer (the DMO) to whom he complained both orally and in writing about lack of treatment for his daughter. In the meantime they had received another admission date (16 March), but a few days after the father made his complaint they received a further letter saying that treatment would have to be postponed until his complaint had been settled.

8. On 13 March the DMO replied to the complainers that he had made a full enquiry into the complaint and that 'it would appear that the information you gave to (the DA) and myself was incomplete in that it appears you have not fully understood the problems in regard to [the daughter's] eyesight'. He confirmed that there had been a problem concerning the supply of a chemical compound which was in very short supply and had been placed on order but not received. The DMO also said that in view of the complainers' approach to him and the DA the consultant felt that they had little confidence in his skill and judgment and in such circumstances would be unlikely to accept the risk which was always considerable in congenital cataract operations and the fact that success could never be guaranteed. He said that as it was possible that the daughter's vision difficulties might not be improved by an operation, the consultant considered it necessary to obtain advice from his defence organisation before he would carry out operative treatment on the complainers' daughter.

9. The father wrote to the DMO on 14 March denying that he had little confidence in the consultant's skill and judgment and saying that he was aware that there could be success or failure in any operation. The DMO replied on 17 March that he had passed a copy of this letter to the consultant for his consideration and would ask him if he would consider discussing the matter direct with the father. In the meantime he suggested that the father contact his own general practitioner (the FP).

10. On 20 March the DMO notified the father that the consultant did not wish to contact him until he had received the advice of his defence organisation and on 2 April the DMO wrote again to the complainers to say that the consultant had been in contact with his defence organisation and on the advice received he had decided to withdraw from the case. The DMO said that another consultant ophthalmologist (the second consultant) was prepared to see the complainers' daughter subject to the concurrence of the FP and he suggested that the complainers discuss the matter with the FP. He said that if they did not agree with this proposal they might like to ask the FP to make other arrangements.

11. The father told my officer that he considered it most unfair of the con-

sultant to withdraw from the case when he had pointed out that he was not questioning the consultant's skill and judgment but was only complaining of the delay in treating his daughter after she had waited so long before it was decided to operate. He said that they had not taken up the offer for their daughter to be seen by the second consultant as their son had earlier been a patient of his and they had no reason to believe that he would be prepared to operate on her. They had therefore arranged for her to be referred elsewhere and there she had her operations in May and June. The complainers felt that it was nonsensical that they had had to take her elsewhere for treatment when there were doctors and facilities available locally.

12. The consultant told my officer that the complainers' daughter had been his patient since 1976. He had found her to be suffering from congenital cataracts, but these had been only partial cataracts and it had been difficult to decide whether she would in future need an operation to remove them and if so when. He explained that such cataracts often do not grow with the eye so as the child grows the cataract covers a relatively smaller portion of the eye. Also her eyesight had been helped by glasses and as a child matures it is possible to obtain more accurate measurements and thus provide better glasses. In this case she also suffered from astigmatism and he felt that this, rather than the cataracts, might be the main problem, in which case removal of the cataracts would not help her vision.

13. The consultant said that the mother had started to press him about undertaking surgery on her daughter as by her account she was being handicapped at school by her defective eyesight. He said he had explained to her that her daughter also suffered from astigmatism and that he did not think that surgery was justified when the chances of improvement were so doubtful. However, in September 1979 he yielded to the mother's persistent arguments about how poorly her daughter was doing at school due to her bad eyesight and agreed to put her on the waiting list for an operation.

14. The consultant told my officer that it had not been his decision but that of the anaesthetist that the proposed operation in mid-February 1980 should be postponed until the complainers' daughter got over her cold. I have seen the notes made when she was admitted on 10 February which record 'seems to have slight U.R.tr. (upper respiratory tract) infn (infection)' and an entry made on 11 February states 'Definite cold, should be postponed. Send home and recall 2–3 weeks'. The consultant said that a fresh admission date had been arranged for three weeks later but during the week before the complainers' daughter was due to be admitted the theatre sister (the sister) informed him that the dispensary was unable to supply a chemical compound (the solution) which was used in the machine used for the removal of cataracts. The consultant said that he checked with the dispensary who informed him that the solution had been ordered but had not arrived. He told my officer that he had not considered it advisable to proceed with a non-urgent operation without this machine and he had therefore decided that the operation would have to be postponed yet again.

15. The sister told my officer that they ordered pharmacy supplies for the theatre block every Monday. On 25 February they had requested 12×500 ml bags of the solution but the order form was returned marked 'O/S' (out of stock) and I have seen that this was the case. The sister said that where this

happened her practice was to seek an explanation from the pharmacy, but she could not now remember doing so or what the outcome was.

16. The district pharmaceutical officer (the DPO) told my officer that he learned only in the course of my investigation that the problem had been the non-availability of the 500 ml bags of the solution, and not a shortage of 10 ml ampoules as he had previously understood. He explained that the 500 ml bags were purchased from commercial manufacturers while the 10 ml ampoules were manufactured by their own pharmacy. They had experienced problems with the manufacture of the 10 ml ampoules but the DPO said that he had been unaware of any problems concerning the supply of 500 ml bags. The two different presentations served different purposes.

17. After making further enquiries the DPO told me that the 500 ml bags of solution were in stock at the time. The member of staff who had been responsible for handling the requisition from the theatre had left the Board's employment so the DPO was unable to offer any explanation as to why it was indicated that this item was out of stock. He said, however, that no member of his staff could recall the theatre staff contacting them to enquire about the future availability of stock or to indicate any urgency. Had this been done the error would have been rectified immediately.

18. The ophthalmic secretary recalled that the consultant had asked her on 27 February to cancel the operation. She told my officer that it was not uncommon for an operation to be postponed and that there could be a variety of reasons for this. In this instance the consultant told her that the cancellation was because the machine was not working. She therefore wrote that same day by first-class post notifying the mother of the postponement. She recalled that the father had telephoned the following day to ask why the operation had been cancelled and she explained to him that a machine needed for the operation was not working. She told my officer that she might well have indicated to the father that the machine had broken down because she was herself under this impression at the time. It was only later she learned that the machine was out of action because the theatre staff could not obtain the solution used with it. She said that as the father was obviously unhappy about the postponement she had suggested that if he telephoned the next day he would be able to speak to the consultant.

19. The consultant said that when the father telephoned him he had said that he was sorry about the postponement but that there was nothing much they could do at the moment due to shortage of the solution. He had also tried to explain that it would be much better for the patient to wait for ideal conditions to undergo the operation rather than attempt it without the best equipment.

20. The consultant said that when the father made his complaint he had felt that it would not be advisable for him to continue treating this patient. He told my officer that he felt that the rapport which was necessary between him and the parents if he was to undertake major ophthalmic surgery was no longer there and that the parents could have little confidence in him and his desire to do his best for their daughter when they complained about such relatively trivial matters. He said that while he had made it clear that the outcome of such an operation was not always certain and her eyesight might not necessarily be improved by it, he was anxious that the parents might well make further complaints if things did not turn out as they had hoped.

21. I have seen that on 10 March the consultant sought the advice of his medical defence organisation who replied on 17 March advising him that it would be quite in order to suggest that since the trust which one would normally expect between a doctor and a patient had been dispelled in this case the patient should be referred to another consultant for further treatment.

22. Also on 10 March the consultant wrote to the DMO giving the background to the case, the reasons for the postponement of the operation and his view that it appeared from the letter of complaint that the parents had little confidence in his skill and judgment. He indicated that in the circumstances he was not happy about carrying out operative treatment on the child and that he was seeking the advice of his defence organisation. The DMO told my officer that in addition to seeking the oral and written comments of the consultant he had also written to the medical assistant who runs the school eye clinic and had made enquiries of the pharmacists to establish what had happened about the supply of the solution. In this respect he was given the same incorrect explanation as my officer was originally given (paragraph 16) about the difficulties concerning the supply of 10 ml ampoules.

23. The DMO said that when the consultant decided to withdraw from the case he suggested to him that he might like to discuss the matter with the parents. The consultant had felt, however, that it would be best if he withdrew completely from the case. To ensure that the complainers' daughter would not be left without specialist care the DMO asked the second consultant if he would be willing to see her. The second consultant told him that he would be happy to if the FP made the referral and the DMO notified the parents of this (paragraph 10).

Findings and conclusions

24. I am satisfied that the decision to send the complainers' daughter home on 11 February was taken solely on medical grounds. However, the decision to postpone the admission planned for 2 March was based on incorrect information. I have been unable to establish exactly how this arose but it should have been revealed in the course of the Board's enquiries. I uphold the complaint that the daughter's operation was unnecessarily delayed and that she was caused unnecessary distress by this error.

25. It is clear that the consultant felt that all confidence between him and the complainers had gone and after taking advice from his defence organisation decided that it would be advisable for him to withdraw from the case. In the circumstances this was a decision he was entitled to take, and alternative arrangements were proposed for treatment to be continued locally. Although it was unfortunate that a further slight delay occurred before his daughter had her operations I cannot ascertain to what extent the father's decision not to accept the Board's proposal also contributed to this delay. In these circumstances I do not uphold this aspect of the complaint.

26. The Board have asked me in this report to express their apologies through the Member to the complainers for the unnecessary delay in their daughter's treatment and this I gladly do. I was pleased to learn that she has since had her operations, with satisfactory results.

Case No. SW.28/80–81 – Care and treatment of psychiatric patient prior to death

Background and complaint

1. An elderly man had been a patient in a psychiatric hospital (the first hospital) virtually continuously since October 1961, and except for the periods October to December 1961 and September 1965 to January 1969 he had been an informal patient. In December 1979 he was transferred to another hospital (the second hospital) for investigation of a kidney complaint and he died there in January 1980.

2. Through her Member of Parliament (the Member) the complainer, a cousin of the patient, complained that:

(*a*) despite having been given assurances that her cousin was free to leave the Male Infirmary (the infirmary) of the first hospital at any time, there were periods between May and November 1979 when he was not permitted to leave;

(*b*) when her cousin's personal clothing was lost he was provided with ill-fitting clothing which made him look 'foolish';

(*c*) her cousin's letters to her were opened before dispatch; and

(*d*) insufficient efforts were made to transfer her cousin to another hospital (the third hospital) as requested by her.

The complainer approached the Health Board (the Board) but is dissatisfied with their replies.

Investigation

3. During the course of the investigation I obtained the Board's comments and I have examined these and other relevant documents from their files and the patient's case notes. One of my officers discussed the complaint with members of the medical, nursing and administrative staff. She also met the complainer.

(a) *The complaint that the complainer's cousin was not permitted to leave the infirmary*

4. In a letter to the Member of 25 June 1980 the complainer described the infirmary as the 'locked-up department' and said that her cousin was kept there from early May to mid-November 1979 despite her protestations that this was causing him serious mental and physical harm. She said that during this time she was regularly and repeatedly assured in telephone conversations, letters and on visits to the hospital that her cousin was an informal patient and could leave at any time. She told my officer that on each occasion she visited her cousin while he was in the infirmary she was ushered through locked doors and that it was her belief that he was kept there to prevent him going to the police about his missing clothes (see paragraphs 10–13).

5. The consultant psychiatrist (the consultant) who was responsible for the complainer's cousin's care told my officer that although he displayed periods of remarkable lucidity he also suffered from bouts of mental disturbance which caused him to become deluded and hallucinated and he was also very unsteady on his feet and subject to frequent falls. She explained that he was normally accommodated in an open ward (ward A) but, because of the staffing arrangements there and the situation of its dormitories on the first floor, when his

mental condition deteriorated the practice was to transfer him to the infirmary where he could be given closer nursing supervision.

6. All the first hospital staff told my officer that no key was necessary to enter the infirmary but that one was required to leave it, and my officer saw that this was so. The consultant explained that the purpose of this security was to prevent the mainly elderly and infirm patients in the infirmary from wandering off and coming to harm. She said that the complainer's cousin had not been kept in the infirmary against his will and that apart from occasions when he was confined to bed because of his physical condition she was unaware of him being prevented from leaving. The first hospital's physician superintendent (the first superintendent) and another consultant (the second consultant) who cared for the patient in the absence of the consultant confirmed this. (The second consultant explained to my officer that there is a separate ward at the first hospital for patients requiring conditions of special security.)

7. A charge nurse (charge nurse A) told my officer that he had explained to the complainer on more than one occasion why her cousin was in the infirmary, pointing out that he was unsteady and constantly falling and that consequently he was safer in a ward which had no stairs. She had seemed reluctant to accept that it was the doctors' decision that he be accommodated in the infirmary. He and another charge nurse (charge nurse B) told my officer that patients who were considered well enough usually spent the day in an adjoining open ward (ward B) to which the complainer's cousin went regularly and neither charge nurse could recall an occasion when his request to leave the infirmary for ward B was refused. Charge nurse B also told my officer that he had discussed the patient's condition with the complainer both when she visited and when she telephoned the first hospital. He said that she was highly critical of her cousin's care and treatment and that he explained to her that her cousin was an informal patient and could therefore leave the first hospital at any time.

8. I have seen letters written by the complainer during the period when she alleges that her cousin was detained in the infirmary against his will and replies from the consultant and the second consultant explaining why he had been transferred to the infirmary and saying that he was free to leave. In July 1979 at the request of the complainer's cousin the consultant wrote to the complainer saying that he had asked to be discharged from the first hospital and wanted to stay with her. The consultant said that she did not consider him fit to leave the hospital unless it was in the care of someone who could give him a great deal of supervision, and after expressing her own reservations, asked if the complainer would tell the consultant what she thought about assuming responsibility for her cousin. The nursing records also have a number of entries indicating that during this period the complainer's cousin went out of the infirmary, generally with the complainer, including one period of a week in September when he stayed with her.

Findings

9. An allegation that a patient's freedom is unnecessarily and illegally restricted is one I take very seriously. In this case the evidence is overwhelming that the complainer's cousin was free to come and go as his physical condition permitted

and that the medical and nursing staff encouraged him to do so. I dismiss this complaint.

(b) *The complaint that the complainer's cousin was provided with ill-fitting clothes which made him look 'foolish'*

10. The complainer told my officer that on an occasion in July 1979 when she and a friend visited the first hospital to take her cousin out for the day she found that he was not wearing his own clothes. She explained that he was a tall man and that he was wearing trousers which were ridiculously short and a cardigan which was ill-fitting and dirty, and she believed that he had been deliberately sent out looking 'foolish'. She said that when she demanded to know where his own clothing was she was told that it was at the cleaners. She found this explanation difficult to accept as his best suit was new and had only been worn a few times. In her letters she indicated that her cousin's clothing was still missing when he spent a week's holiday with her in September. He was again sent out wearing trousers which were far too short.

11. It was only in respect of the circumstances surrounding this latter occasion that a formal complaint was made to the Board, and the District Administrator (the DA) wrote to the complainer on 7 December explaining the problems of ensuring that her cousin's personal clothing could be used at all times. In a letter dated 9 May 1980 to the complainer the Board's acting secretary explained that because of her cousin's incontinence his personal clothing had to be dry-cleaned and as there were no facilities at the hospital it was sent elsewhere, which invariably took a few weeks. He said that when her cousin's suit had been returned it had inadvertently been delivered to the wrong ward and could not be found immediately and he added that this was particularly unfortunate in that it was mislaid at the time when he had wanted to look his smartest.

12. Charge nurse A told my officer that the patient was an awkwardly built man who was both tall and stout. He said that he possessed very little clothing of his own. (I have seen a list of his personal clothing when he was transferred from the infirmary to ward A in November 1979 which appears to confirm this.) He was reluctant to spend money on himself and as he was often doubly incontinent this posed great problems for the nursing staff as they had difficulty in finding suitable hospital clothing to fit him. Charge nurse B recalled the complainer asking him at the end of August 1979 about her cousin's missing clothing. He said that he made some enquiries and established that his suit had been sent for dry cleaning but had not been returned. Both charge nurses denied that there had ever been an occasion when the complainer's cousin was intentionally made to look foolish: Charge nurse B said that, on the contrary, when patients were going out of the hospital the staff tried to dress them as well as possible. The consultant and the second consultant corroborated these details about the complainer's cousin and of the first hospital's policy.

Findings

13. It seems highly probable that the complainer's cousin sometimes wore clothes that did not fit him, but I believe that given his incontinence and his stature the nurses did their best. I am completely satisfied that at no time did they intend to make him look 'foolish'. I do not uphold this complaint.

(c) *The complaint about the opening of mail*

14. In a letter of 15 August 1979 to the Community Medicine Specialist (the first CMS) of the Health District (the district) the complainer stated that she had received two letters from her cousin both of which had been 'opened and closed by someone who must have been used to this sort of job'. She said that there were no dates on the letters but that from the contents of one of them she estimated that it had been written two weeks previously and she complained that the letters had not been posted through the first hospital channel but had ordinary post office markings. In reply to the complainer of 9 May 1980 the acting secretary said that 'Incoming mail addressed to [her cousin] was always handed to him unopened. Outgoing mail, provided it was adequately addressed, was posted unopened'. He went on to detail the statutory provisions of the Mental Health (Scotland) Act 1960 which govern the handling of patients' mail and he concluded by saying: 'These conditions are rigorously applied and there is absolutely no question of censorship'. The complainer showed my officer the letters in question: there were three of them all postmarked with the same date. Each of the envelopes appeared to have been opened along the top edge and re-sealed with transparent tape. None of them bore the first hospital's franking machine imprint. The letters themselves bear no date and have not been censored in any way.

15. The first superintendent and Charge nurse A told my officer that patients' mail was only intercepted if a patient's relative had requested that action after receiving upsetting letters, and the consultant said that she was not aware of any occasion when patients' mail had been tampered with. My officer learned that patients' letters could be posted either by being handed into the first hospital's own reception area or directly into a post box which was at the main gate, and when they were posted there the first hospital franking would not of course appear. Properly addressed letters which were taken to the reception area were stamped and then collected by the postman. Charge nurses A and B said that there was no question of censorship of the complainer's cousin's mail and the only explanation they could give for the apparent re-opening of the envelope was that he did it himself. Charge nurse B and a third charge nurse said in written statements that the complainer's cousin was in the habit of writing notes containing odd and bizarre statements on scraps of paper without accompanying envelopes which he would leave in the charge nurse's office. These were either destroyed or placed in his case notes. I have seen examples of these documents in the case notes.

16. My officer spoke to the receptionist at the first hospital who stated that patients' outgoing mail came to her for stamping and posting. She said that each letter should have been accompanied by the correct postal fee but if it was not she would stamp it on the franking machine. She knew nothing about patients' mail being opened prior to dispatch and doubted that this would happen.

Findings

17. Sections 34 and 102 of the Mental Health (Scotland) Act 1960, set out the circumstances in which postal packets addressed to a patient (whether detained formally or not) may be withheld from him and when postal packets from a

patient may be withheld from the post office. I am satisfied the first hospital staff were aware of the procedure and abided by it. The letters received by the complainer do appear to have been tampered with but I am satisfied that the hospital staff were not responsible. I do not uphold this complaint.

(d) *The complaint about the efforts made to transfer the complainer's cousin*

18. In a letter she wrote to the first superintendent on 23 November 1978, just prior to her first visit to the first hospital, the complainer suggested that if her cousin was transferred to the third hospital he would have more visitors as there were quite a few relatives and family friends there. When she visited her cousin on 28 November 1978 she was seen by the second consultant who explained to her that her cousin's mother had written in October with a similar request. He told her that the first superintendent had made enquiries of the third hospital but had been told that because of admission difficulties they were not in a position to accept a patient from outwith the area which they served. The first superintendent, replying to the complainer's letter on 28 November, restated the situation but suggested that she write direct to the superintendent (the second superintendent) at the third hospital. She did so and he replied on 13 December saying that because of overcrowding and staff shortages he regretted that the complainer's cousin could not be accepted there at that time. He also said that he had established that her cousin was happy at the first hospital and was being well looked after there.

19. In a letter dated 5 February 1979 the complainer again raised the subject of transfer, and the consultant replied on 14 February saying that because of the admission problems of the third hospital there would need to be a very convincing reason for them to accept her cousin and she asked the complainer to supply information on the people who would be likely to visit him there. The complainer wrote to the consultant on 23 February telling her that she had written to several people in the area of the third hospital who 'would certainly' visit her cousin. On 19 March the consultant wrote to the second superintendent outlining the complainer's cousin's medical history and requesting that he consider accepting him as a patient, but at the same time she told the complainer that she doubted whether the third hospital would be able to accept him. In a letter dated 3 April the complainer told the consultant that a relative had said he would visit her cousin from time to time if he were transferred. The consultant replied on 5 April informing her that the second superintendent had requested the names and addresses of people who would visit should her cousin be transferred, as this might strengthen his hand in accepting her cousin as a patient. On 1 May the consultant reminded the complainer that the third hospital were awaiting the previously requested list and on 14 May the complainer wrote that this had been forwarded to the second superintendent.

20. The second superintendent wrote to the complainer in June stating that his hospital could not accept her cousin at that time. On 28 June the complainer wrote to the consultant telling her this and expressing her concern about the long delay in moving her cousin. She pointed out that it was more than six months since she had first written on the subject. She also said 'Everyone who hears [her cousin's] history is shocked that he was not moved *immediately* his case was brought to light'. The consultant in her reply of 2 July stated that there was nothing further that the hospital could do to bring about a transfer as the

decision rested with the second superintendent and his colleagues. She reiterated the situation that existed at the third hospital and she said that she could offer no more help towards getting a transfer there.

21. The complainer wrote to the second superintendent again and he replied on 18 September stating that it had already been decided 'to maintain the *status quo*'. The complainer subsequently wrote to the Member about the failure to transfer her cousin and he wrote to the Minister of Health and Social Work (the Minister). On 3 October the Scottish Home and Health Department (SHHD) wrote to the Board asking them for a report on the situation and simultaneously wrote to the health board (the second Board), who are responsible for the third hospital, asking for their comments. The second Board replied to SHHD on 22 October stating that the request had been considered; that the third hospital had a waiting list of patients living in their own catchment area; and that no priority could be given to a patient already accommodated in a hospital although it might prove possible in the future to arrange an exchange. On 26 October a Community Medicine Specialist at the Board (the second CMS) replied to the Member direct outlining the attempts that had been made to effect the transfer but explaining that the difficulty lay with the third hospital's admission problems.

22. The first superintendent told my officer that the complainer's cousin considered the first hospital to be his home and he explained that in the 1960s there had been two attempts to discharge him, the first time home and the second time to a rehabilitation centre, but on each occasion he had been re-admitted almost immediately. He said that at the request of his mother there had been a previous attempt to move him to the third hospital but this had had to be abandoned as the complainer's cousin himself had consistently refused to go there. The first superintendent said that in 1978 following the requests of the complainer's cousin's mother and the complainer he discussed the matter with the second superintendent whom he knew very well and who wanted to help, but the third hospital had found it impossible to accept the request for transfer as it was suffering staff shortages which had resulted in the closure of two wards.

23. The consultant told my officer that she was very doubtful of the value of transferring the complainer's cousin to the third hospital and she considered that such a move could have had a detrimental effect on his condition, but she had gone along with the suggestion that a transfer be tried.

Findings

24. I have found that despite their reservations that the transfer might not be in the complainer's cousin's medical and social interests the consultant and the first superintendent made strenuous efforts to meet the complainer's request for her cousin's transfer to the third hospital and they bear no responsibility for that hospital's inability to accept him. I do not uphold this complaint.

(e) *The complaint about the Board's handling of the complaint*

25. From the time when she first visited her cousin in November 1978 the complainer corresponded regularly and at length with the doctors who cared for him and I have already referred to some of the letters she wrote. On 9 July 1979 she wrote to the Department of Environmental Health of a District Council

outlining her cousin's history and she complained that he was being kept in the infirmary despite the fact that this was having an adverse effect on his condition. She also referred to the missing clothing and the delay in bringing about his transfer to the third hospital. This letter was acknowledged and forwarded to the district as was her second letter of 26 July. On 27 July the first CMS told the complainer that her letter of 9 July was being referred to the first superintendent and he wrote to the complainer on 30 July. On receipt of the complainer's letter of 26 July the first CMS wrote to the first superintendent again, asking him about her cousin, and on 3 August he wrote to the complainer herself explaining that he had done this.

26. The complainer wrote to the first CMS on 15 August (see paragraph 14). This letter was acknowledged on 16 August and as the first CMS was on leave passed to the DA who in turn forwarded it to the first superintendent. On 20 August the first superintendent wrote to the DA saying that he was prepared to send a report as requested but that, after discussing the situation with the consultant, they considered that as the complainer was not the next-of-kin she was 'greatly exceeding her rights in her constant demands'; and he asked if the matter should be referred to the Legal Adviser of the Scottish Health Service. He concluded by stating that the consultant felt that she could 'no longer usefully continue to reply to the barrage of letters from [the complainer]'. The first superintendent prepared a report on the complainer's cousin which he sent to the first CMS on 29 August.

27. The complainer wrote to the first CMS on 2 October reminding him that she had heard nothing from him since his letter of 3 August. The DA replied on 5 October explaining that the reason she had not had a reply was that during discussions with senior staff at the first hospital he had understood that her cousin had been discharged into her care on 30 August. He had therefore regarded the matter as closed but had since been informed that her cousin had only been on holiday with her at this time. The DA apologised for this misunderstanding. He said he would look into the points she had raised and would write again. He also pointed out that her cousin's mother was the next-of-kin and it was only because she herself was a patient in hospital that the correspondence was being conducted with the complainer. She states that she did not receive this letter and on 8 November she wrote to the second CMS complaining that she had had no reply from the district since 3 August and she repeated her other complaints. The second CMS passed this letter to the district for reply on 14 November.

28. On 7 December the DA replied to the complainer and added: 'All possible information has been given to you by the many different persons involved in this case and my colleagues and I are agreed, bearing in mind that you are not in fact [her cousin's] next-of-kin, that we can no longer enter into correspondence with you on this matter', and he concluded by saying that her cousin was an informal patient and could discharge himself at any time.

29. The complainer replied to the DA on 10 December asking 'how can you close a correspondence which has never begun?'; she stated that she was about to attempt to get her cousin to nominate her as his next-of-kin; she asked how he could suggest discharging such an unstable man as he had suggested her

cousin was; and she pointed out that he did not even seem to know that her cousin had been transferred to the second hospital for treatment.

30. On 11 December the complainer wrote to the second CMS saying that she had received only an acknowledgment to her letter of 8 November and she complained about the DA's letter to her of 7 December; she told him that her cousin was no longer in the first hospital; she expressed the hope that he would soon be moved to the third hospital; and she asked what her position was as a concerned relative.

31. On 10 January 1980 the complainer wrote to the secretary complaining that the two letters she had written to the second CMS had not been answered and on 15 January the second CMS replied to her explaining that her letter of 8 November had been passed to the DA who had replied to it in his letter of 7 December and that her letter of 11 December had been acknowledged. About her position as a concerned relative he said that they were always happy when relatives took an interest in patients in hospital and he continued: 'However, information about patients in hospital is a matter of confidence between the patient and the doctors, nurses and others who care for them. I have examined our records and correspondence about the treatment and care of [her cousin] . . . . I am satisfied that the treatment and care provided for him over that long period has been, within the building and staff resources available, reasonable and adequate and that there are no good grounds for complaint about his treatment as a whole'. On the same day the acting secretary wrote to the complainer expressing the hope that the second CMS's letter had been helpful and reassuring.

32. The complainer wrote to the secretary again on 26 January saying that she had found the second CMS's letter neither helpful nor reassuring and she complained that she had waited since August for answers to her enquiries but that she had not received any. She reiterated the points she had raised before and she also told him that she had just learned of her cousin's death.

33. The second CMS discussed the situation with a Medical Commissioner from the Mental Welfare Commission (the MWC) who advised him that if necessary the MWC would consider becoming involved at a later date but that in the meantime the Board should continue to correspond with the complainer. The acting secretary wrote on 1 February to the complainer expressing his condolences on her cousin's death. He assured her that her representations and requests had all been thoroughly investigated and replied to and he concluded by saying that as she was not the next-of-kin the information which could be given was limited.

34. The complainer wrote to the secretary again on 16 February repeating her earlier complaints and on 22 February he replied that he would once again review the papers on the subject. On 26 March the complainer brought her complaints to the Minister. On 24 April the SHHD asked the Board to reply direct to the complainer. On 9 May the acting secretary replied to her at length saying that they were happy when relatives took an interest in patients and he pointed out that her cousin's mother, his next-of-kin, had taken a continuing interest in his care and business affairs. He said that information about patients' treatment was a matter of confidence; and that the medical staff were satisfied that her

cousin's care and treatment was reasonable and adequate. He outlined the course that her cousin's condition and treatment had taken since his admission to the hospital in 1961 and he went on to answer the specific questions which she had raised. In reply to the question about why her cousin was locked up in the infirmary he explained that her cousin's move to the infirmary was decided by the medical staff and he ended 'As far as I can ascertain he was not locked up'.

35. The complainer remained dissatisfied with this reply and on 25 June she wrote to the Member explaining her disquiet and she asked him to refer the matter to the Scottish Office. The Member wrote to the Minister on 2 July who replied on 23 July saying that as he saw it the complainer's continuing concern seemed to be the question of her cousin's physical containment and the censorship of his correspondence. He said he would be asking the chairman of the Board to give further information on these two points and in particular on the former as the previous answer to this had not been very expansive. On 1 August SHHD wrote to the Board and asked that those aspects be looked into.

36. On 20 August the chairman replied to the Member explaining why the complainer's cousin was transferred to the infirmary and that he was not prevented from leaving except when he was confined to bed; on the censorship of correspondence he restated what the complainer had already been told (see paragraph 14) and he enclosed copies of three notes written by the complainer's cousin when he was unwell which had been addressed to no one in particular but had been retained on his case notes, and he also enclosed signed statements from two charge nurses concerning the handling of patients' mail. He concluded by stating that there had been a great deal of correspondence with the complainer and that he felt that they had tried to be as understanding and co-operative as possible but that no purpose could be served by prolonging it. He suggested that if the complainer remained dissatisfied she should pursue the matter with me.

Findings

37. The complainer was a tireless letter writer: between November 1978 and February 1980 she wrote some twenty-five letters to the first hospital, the district, the Board and the third hospital. I found her letters long and needlessly repetitive. There was a delay between August and October 1979 (see paragraph 27) when due to a misunderstanding, she did not receive an answer. However, when I review the Board's handling in the context of all the correspondence and conversations with her about her cousin's care I find it sympathetic and patient. I do not uphold this complaint.

Conclusions

38. The complainer's cousin had been in the hospital for over eighteen years and throughout this time he had had very few visitors. When the complainer demonstrated her interest in and concern for her cousin the consultant and nursing staff welcomed this and gave her every encouragement. I have not upheld any of her complaints and I have been impressed with all I have learned about the considerate care given to her cousin. Although I do not doubt that her intentions were entirely praiseworthy, her complaints and the persistence with which she pressed them were alike unreasonable.

Case No. WW.3/79–80 – Refusal to provide crutches

Complaint and background

1. The complainant fractured his leg in two places on 30 August 1978 while on holiday. He was treated at a hospital (the hospital) and taken to his holiday home the same day by ambulance. He complains that:

(*a*) he was caused unnecessary suffering during the diagnosis of, and treatment for, his fractured leg;

(*b*) although he had been told that he would be unable to walk for 48 hours, staff at the hospital refused to supply him with crutches when he left; and

(*c*) the Health Authority (the Authority) were very slow in responding to his complaints, and failed to reply adequately to them.

2. The complainant put his complaint to the Secretary of his local Community Health Council (the first CHC Secretary) who referred it to the Secretary of another Community Health Council (the second CHC Secretary) who in turn passed it to the Authority.

Investigation

3. During the investigation the written comments of the Authority were obtained and I saw these and the relevant correspondence. My officers discussed the complaint with members of the staff involved and one of them spoke to the complainant. They were unable to see the junior doctor who first examined the complainant because he had left the country.

(a) *The complaint about unnecessary suffering*

4. The complainant told my officer that when he entered the casualty unit he had been aware of an acute pain in his ankle and a persistent 'clicking' in the back of his knee. He told the sister in charge of the unit about these pains and she passed the information to the doctor who had first examined him. After feeling his knee, the doctor told him that it was only a pulled muscle. X-rays of his lower leg were taken but not of his knee. He had had to turn his ankle through about 90 degrees when the x-rays of his ankle and lower leg were taken and this had aggravated the pain in his knee.

5. The complainant went on to say that when he was taken to the plaster room, the plaster technician asked him to lie on the table and relax. The complainant asked what he was going to do and the technician showed him by turning his good ankle to the required position. The complainant told the technician that that would be too painful. The technician then said that he would be late for a 4.30 appointment if he had to wait for the complainant to have an anaesthetic. The complainant said he was eventually given an anaesthetic and that a plaster was applied to his ankle and to his lower leg just below the knee.

6. In his letter to the second CHC Secretary, the first CHC Secretary said that on two occasions the technician started setting the ankle without an anaesthetic and that he stopped only when the complainant protested. He also said that subsequent x-rays taken at a hospital near his home, revealed a second fracture about one-inch below the knee but above the plaster applied at the hospital.

7. The consultant orthopaedic surgeon (the consultant) responsible for the complainant's treatment told him in a letter dated 8 December 1978 that he had studied the x-ray and agreed that the injury sustained was a severe one for which he would have expected a general anaesthetic to be given before plaster was applied. He sympathised with the distress the complainant had suffered.

8. In the Authority's letter of reply to the complainant dated 7 June 1979 they said that the standard examination procedure for x-raying an ankle requires more than one view to be taken. The complainant had been asked to turn his foot so that an oblique view could be taken; but he had refused because it would have been too painful. A modified technique had therefore been used. They said that they had been unable to identify the plaster technician who was alleged to have made the remark referred to in paragraph 5 but, in view of what the consultant had said about the severity of the injury and the need for a general anaesthetic, they apologised to him for what was a 'particularly stupid and unwarranted comment in the circumstances'.

9. The consultant told my officer that, when he had questioned the junior doctor about the complainant's treatment, the doctor could not remember the case. Having reviewed the treatment the complainant had received, the consultant said it was clear that the doctor concerned had not recognised the severity of the injuries, but it was a difficult case to diagnose. He accepted that the whole leg should have been x-rayed but, in his opinion, the complainant had nonetheless received acceptable treatment – which was a weight-bearing plaster below the knee. If a full diagnosis had been made at the time the only difference in treatment would have been the administration of an anaesthetic at an earlier stage. But he might have been advised to stay in hospital overnight and asked to attend a fracture clinic for follow-up x-rays and possible re-manipulation.

10. The senior plaster technician (the technician), who was on duty at the time, told my officers that he did not recall the complainant. He said that patients were referred to the plaster room by the doctor in the casualty unit with details of the plastering required. This would be done either on a form or by telephone and patients referred in this way would not require an anaesthetic. If the bone needed setting it would be done, not by the technician, but by a doctor and the patient would be anaesthetised. Normally patients with a fracture such as the complainant's could move the foot to the required angle before plaster was applied. When plastering he might ask a patient to pull his foot up to a '90 degrees position' but he would never rotate the ankle. If, as it appeared, the complainant had not been able to move his foot to the necessary angle, he would have been referred back to the doctor for him to reconsider the need for an anaesthetic. If an anaesthetic were used the plastering would be done in another plaster room. The technician said that, as he did not have set appointments, he could not understand the complainant's remark about the reluctance to refer him for an anaesthetic because of another appointment.

11. The superintendent radiographer told my officer that none of the staff in the x-ray department remembered the complainant. She said that, although a patient might be asked to move his ankle, the x-ray staff would not try to rotate it if he was unable to do so. Three x-rays had been taken and, according to a form completed at the time by the radiographer who had x-rayed the complainant, he would not turn his ankle for the oblique view to be taken. A modified

procedure for taking the x-ray had therefore been used and she considered that the need for this modified procedure indicated that the complainant's ankle had not been moved by the x-ray staff.

Findings

12. Although none of the hospital staff can remember the complainant, I have no reason to doubt that he was first sent to the plaster room for plastering without anaesthetic. This would have been a decision taken by the examining doctor solely in consequence of the exercise of his clinical judgment and is not for me to comment upon. But the consultant has said that he would have expected an anaesthetic to have been given in this case and has apologised to the complainant for the distress he suffered. But that apart, I am not satisfied that he was subjected to any suffering by the staff concerned which was not an unavoidable accompaniment of his accidental injury. I do not therefore uphold this aspect of his complaint.

(*b*) *The complaint about the crutches*

13. The first CHC Secretary said that, although the complainant had been told not to walk for 48 hours, he was discharged from the hospital with a wet plaster and without crutches. The hospital had said that they did not have any. The complainant and his family left the area the next day and he had suffered considerable distress on the way home, though this had been eased when a hospital en route prescribed pain-killing tablets 'and provided crutches'. The complainant said that, in fact, he had not taken advantage of the hospital's offer to provide him with crutches because he was told he would be able to get them from a hospital in the area where he lived.

14. The complainant told my officer that he was told in the plaster room at the hospital that crutches would not be provided. And he said that when he was leaving the hospital in a wheelchair, the sister on duty apologised to him and told him that it was hospital policy not to lend crutches to patients from outside the immediate area. He had offered to pay a deposit and sign a guarantee to return the crutches, but his offer had been refused.

15. In his letter to the complainant the consultant said he agreed that it was wrong to send patients away from the hospital with a recently applied plaster and without crutches. It was not a policy that the hospital wished to continue; but people had not returned crutches in the past and stocks had been depleted. The Authority's reply to the complainant endorsed the consultant's comments. They said that considerable time and energy were spent in chasing the return of items of equipment on loan and that the attitude and indifference of some patients created problems for others. They apologised because it had not been possible to provide crutches.

16. In an interview with my officer the technician said that patients who were given non-weight-bearing plasters would need crutches and he would issue them, regardless of where the patient lived. However, it had been the policy of the consultant's predecessor (who had retired in March 1978) that crutches would not normally be issued to patients with weight-bearing plasters on the grounds that, once the plaster had dried after approximately 48 hours, the patient should walk on the leg as much as possible; and crutches tended to discourage this.

However, the technician said, this was not a hard and fast rule and he would take account of the patient's condition and his pain threshold. But, as the casualty department sometimes ran out of crutches, he was reluctant to issue them to patients outside the immediate area if he had only two or three pairs left. In these circumstances he sometimes had to refuse crutches to patients for whom they ought to have been provided and would have been, had stock levels permitted. If his stock were low, crutches were available from the physiotherapy department but that was of use only if the crutches were required when the department was open – Mondays to Fridays between 09.00 and 16.00 hours. (The complainant had left the hospital after 16.00 hours.)

17. With effect from March 1980, or thereabouts, crutches had been issued to patients with weight-bearing plasters who, under the previous consultant surgeon's policy, would not have been given crutches. This decision had been taken by the technician who considered that he had better start issuing crutches to patients with weight-bearing plasters. The technician added that there was now no shortage of crutches.

18. The acting hospital administrator told my officer that monthly checks were now kept on stock levels of crutches and they were ordered from a central store rather than direct from the manufacturers. She thought that this should ensure that crutches would be available at all times despite fluctuations in demand.

19. In his interview with my officer the consultant said that he thought the issue of crutches to the complainant had not been medically necessary but that they should have been issued, if only on humane grounds. He considered that the decision whether or not a patient should be loaned crutches ought normally to be a medical one, though the technician could decide in cases where there was no doubt. He said that until he had made enquiries about the complaint, he had not been aware of the previous consultant's policy of not issuing crutches to patients with weight-bearing plasters, nor of the technician's reluctance to issue crutches to patients from outside the area when stocks were low.

20. The consultant agreed that it was open to him to issue a revised policy as far as his patients were concerned, but the technician and his staff also dealt with the patients of two other consultants in the department and he could not impose his views on them. But, in the event, he considered that there was no need to change things as the present arrangements worked satisfactorily: as far as he knew the complaint was the only one the hospital had received about a refusal to issue crutches.

Findings

21. I have no doubt that the complainant was told that he could not have crutches loaned to him because he lived outside the immediate area. Indeed, the consultants' letter to him said that this was the reason; and his comments were endorsed by the Authority in their reply to him. He says he was also told that the hospital had no crutches available. I have been given another reason – that it was not then the medical policy to issue crutches to patients who had weight-bearing plasters. The consultant told my officer that the decision whether or not to provide crutches should normally be a medical one; yet in about March

1980 the technician himself evidently decided to change the policy. The picture that emerges is one of considerable confusion on the part of the Authority.

22. I think it was unreasonable to have withheld crutches from the complainant for any reason other than a medical one and I uphold this part of his complaint.

(c) *The complaint about the Authority's response*

23. The complainant discussed his complaint with the first CHC Secretary who, at his request, wrote to the second CHC Secretary on 25 September 1978 to lodge a complaint. On 16 October the second CHC Secretary wrote to the Authority enclosing a copy of the letter of 25 September. She asked the area administrator to give the matter his attention and let her know the outcome in due course. The Authority wrote to both CHC Secretaries on 23 October saying that the complaints were being investigated.

24. The consultant wrote direct to the complainant on 8 December (see paragraphs 7 and 15). He apologised for the delay in replying to the complaint, but explained that the junior doctor involved had been on study leave. He sympathised with the distress the complainant had suffered, but regretted that the casualty officer could not remember the exact circumstances of his attendance at the hospital. He also regretted that the complainant had unpleasant memories of the hospital. The consultant told my officer that he always preferred to reply direct to complainants, rather than through the administration, but he had sent a copy of his letter of 8 December to the administration.

25. The Authority replied to the complainant on 7 June 1979 and sent a copy of the letter to the two CHC Secretaries (who had meanwhile been pressing them for a reply). They apologised to the complainant and the CHC Secretaries for the delay in replying and they explained what would probably have happened in the x-ray department and their inability to establish the identity of the technician. They also said that they endorsed the consultant's comments about the provision of crutches and they expressed their 'sincere apologies for the considerable distress and inconvenience you suffered'.

26. The area general administrator who had replied to the complainant on behalf of his Authority told my officer that the reason for the delay between the consultant's letter of 8 December 1978 to the complainant, and the Authority's substantive reply of 7 June 1979 to him, was that the investigating officers concerned needed to clarify certain matters after their initial enquiries, and that they had many other administrative commitments and priorities more directly related to patient care during the period in question. He regretted that no further explanation could be offered to account for the unfortunate delay.

27. My examination of the Authority's papers shows that they actively pursued the complaint up to February 1979 but, from then on, little happened until they eventually replied in June.

Findings

28. Neither the Authority nor the consultant told the complainant that there could have been any reason that he was not provided with crutches other than the fact that he lived outside the area. I am not surprised that he thought this

unacceptable. I consider that the Authority were far too ready to accept this explanation and I think that, to that extent, their reply was deficient.

29. I find no fault with the Authority's replies on the other aspects of the complaint. They could not be sure of the facts of the case, but they apologised generously both for the distress the complainant had suffered and for the delay in dealing with his complaint. I do not think they are called upon to do more.

Conclusion

30. I have set out my findings in paragraphs 12, 21 and 22, and 28 and 29 of my report. The Authority have confirmed to me that there is now no restriction on the issue of crutches to patients living outside the area and that stocks are sufficient to meet the demand. I hope the complainant will be content with this assurance and with the apologies that have already been given him.

Case No. WW.12/79–80 – Attitude of consultant and nursing care of daughter prior to her death

Complaint and background

1. The complainant's three year old daughter was taken ill in August 1978. She was admitted to the paediatric ward (the ward) at a hospital (the first hospital) on 7 September and remained there until her discharge on 15 September. She was subsequently seen there on three occasions as an outpatient before admission to a second hospital (the second hospital) on 25 September. She died on 19 October 1978.

2. The complainants made representations to the Health Authority (the Authority) through their solicitors (the solicitors) but were not satisfied with the replies they received. They complained to me and I agreed to investigate their complaints that:

(*a*) the consultant paediatrician (the consultant) at the hospital was unsympathetic towards them; on several occasions he disregarded their own observations and concern about their daughter's deteriorating condition; and on one occasion refused to make a domiciliary visit or to see her at his clinic because of 'prior commitments'.

(*b*) the paediatric ward at the hospital was overcrowded; although some of the children had skin complaints, only one bath was available for them and this was badly stained; the children were made ready for bed from 4.00 pm onwards;

(*c*) at times there was an acute shortage of nursing staff on the ward;

(*d*) the food was poor; they were told not to bring in milk for their daughter; and they had conflicting information about whether or not she was eating;

(*e*) she contracted a cough and a cold as a result of sitting in a draught with her hair wet after bathing;

(*f*) although the mother was told that her daughter was happy in the hospital playschool, a relative who visited her there found her without shoes, socks or pants, ignored by the staff, and with a high temperature;

(*g*) after being weighed at the hospital their daughter was dragged by the sister in an unsuccessful attempt to make her walk;

(*h*) there was a considerable discrepancy in their daughter's weight as recorded on 25 September at the hospital and a few hours later at the second hospital;

(*i*) a member of the nursing staff implied that the father had been a nuisance; and

(*j*) the Authority's response to their complaints was unsatisfactory.

Investigation

3. During the investigation I obtained the written comments of the Authority and I saw these, the relevant correspondence and the medical records. Members of my staff met the complainants and interviewed the consultant and the hospital staff concerned.

4. The National Health Service Act 1977 prevents me from investigating decisions which, in my opinion, are taken solely in the exercise of a doctor's clinical judgment. In this report references to the medical background are included only in order to place the complaint in context.

5. The references in the following paragraphs to the father's 'account' relate to his summary of events in diary form which he put to the Authority.

(*a*) *The complaint about the consultant*

6. The father said that on 29 August they asked their family doctor (the FP) to call as their daughter was not responding to treatment. When the FP saw her he said that her symptoms were unfamiliar to him. He telephoned the consultant at the hospital and gave him details of the symptoms. The consultant diagnosed toxic erythema and said that he would call the following day. The consultant visited at 3.00 pm on 30 August and confirmed his diagnosis. He did not prescribe any treatment and would not risk giving an antibiotic because the condition was already a reaction to prescribed drugs. At the request of the FP the consultant made further domiciliary visits on 1 September (with his House Officer), and on 6 September when he made arrangements to admit the complainants' daughter to the hospital.

7. On 9 and 11 September the father spoke to the consultant on the ward and drew his attention to his daughter's 'obviously distended stomach' but the consultant considered that it was 'of no consequence'. He also told the consultant that his daughter was 'an emotional disaster area' and that she was not speaking, walking, eating or taking any interest in her surroundings, but the consultant dismissed this as 'nonsense' and would not heed their 'impassioned pleas' about her condition.

8. After examining the complainant's daughter on 15 September the consultant discharged her but arranged to see her as an outpatient on 18 September when the mother again expressed great concern about her daughter's general condition and distended stomach. The consultant examined her but did not prescribe any treatment and told them to come back to the ward in a week. The father described the consultant's attitude as 'one of complete disregard for what purports to be a potentially serious situation'.

9. On 21 September the daughter's condition gave 'great cause for concern'. Having failed to get in touch with the FP the complainants telephoned the consultant at the hospital and asked him to make a domiciliary visit, but he said he could not come that day because of 'prior commitments'. The father offered to take his daughter to the hospital there and then but the consultant refused and advised them to bring her to see him the following morning. This they did, but he was 'still completely unconcerned' despite their own expressed belief that their daughter's skin condition was getting worse each day, and their anxiety about her incontinence. The consultant did agree to see her again on 25 September, but the father thought that his family were 'helpless people totally in the hands of a supposedly eminent man'.

10. When the consultant saw the complainant's daughter on 25 September, he told the mother that a consultant dermatologist whom he had asked to see the daughter on 27 September would not now be able to come and 'reluctantly he was going to pass us over to a colleague' in the second hospital. An hour later arrangements had been made for the daughter to be seen in the paediatric clinic there at 2.00 pm the same day.

11. In a letter dated 28 January 1980 to my office the father said that the consultant's attitude 'was and presumably still is one of an almost God-like person to whom parents were a nuisance value as only he knew best . . . a frightening spectacle'. And, when interviewed by my officers, he said he felt that the consultant's uncaring attitude towards them as parents of sick children was wrong and bound to annoy, and his apparent lack of concern for the condition of his patients appeared cold and highhanded.

12. In an interview with my officer the consultant said that when he had seen the complainant's daughter at home on 1 September he thought that her parents were expecting a rapid improvement in her condition. He said he did not think he would have said that her distended stomach was 'of no consequence' when he saw her on 9 September or that on 11 September he had dismissed the mother's account as nonsense. He had agreed that the daughter was emotionally difficult and that there had been some sign of distention; and he had probably said 'don't worry about it'. He said it was very difficult to know what to say when one had only a slight feeling that a condition might be serious and he felt that he might have been over-reassuring. But he was not, either then or later, unconcerned.

13. The consultant said that the daughter's condition should have returned to normal after, at the most, three weeks; but it had not done so and he was therefore concerned. He said that he had been afraid to prescribe even an antihistamine in case it caused her condition to 'flare up' again. He had been surprised at the complainant's remarks because he felt that he had had a good and friendly relationship with them.

14. The consultant told my officer that the mother knew she had direct access to him on the ward: he never insisted that she approach her FP first. He said he remembered the father's telephone call on 21 September very clearly. It was at about one o'clock and he was on the point of leaving the hospital. He told him that if they could not see their own doctor they should come to the hospital the following day and see him between 8.30 and 9 o'clock.

15. In his written comments to me he said that, when the father had telephoned him to request the domiciliary visit, he had explained that he could do this only if requested by their FP or another family practitioner, but that, if this could not be arranged, he would be willing to see the daughter during his ward round the following morning (which he did). He said that the father had telephoned him as he was about to leave his outpatient clinic and that he would be away from the hospital during the afternoon. He also said that, if the complainants considered that he was unsympathetic and had disregarded their observations and concern, they would surely have asked their FP about the possibility of seeking medical advice elsewhere. But that view had certainly not been reflected in their relationship with him – a relationship which he thought had been friendly and open. The fact that he was concerned and sympathetic was demonstrated by his actions in visiting their daughter at home on three occasions; obtaining a dermatological opinion to confirm his diagnosis and treatment; and, when no improvement had come about within the expected time, referring her to the second hospital.

Findings

16. The complainants' view of the consultant's relationship with them is clearly at odds with that of the consultant. This is a difference that I have been unable to resolve. The consultant has mentioned the difficulty in deciding how much to tell parents when he is uncertain whether a patient's condition is serious; and he has said that in this case he may have reassured the parents too much. I think that the complainants, as a result of their very understandable anxiety about their daughter's condition, interpreted this as a lack of concern. I appreciate the consultant's difficulty. It is not easy to strike a balance between being over-encouraging and over-alarming to relatives. But I have seen no evidence to support the complainants' contention that the consultant was unconcerned about their daughter's condition or that he disregarded their observations about it. As to the complaint that their request for a domiciliary visit was refused, the consultant has explained why he could not accede to it and I believe he told the father the reason. I do not uphold the complaint against the consultant.

(b) *The complaints about the overcrowded ward, the bath, and the time the children were made ready for bed*

(i) *The overcrowded ward*

17. In his account for 8 September the father said that the amount of room between the cot beds was 26 inches and that the conditions were "utterly cramped'.

18. My officer checked the bed occupancy figures over the period concerned and found that on one of the nine days there were 23 patients, on all other days there were 22 or less, and on five of these there were less than 20 patients.

19. When interviewed by my officer the Sector Administrator (the SA) said that the ward had been designed to take 22 beds, 16 of which were in the open ward where the complainants' daughter had been a patient and six in a side ward. It was possible that an extra cot had been put in the ward for part of the period when the daughter was a patient there, but apart from that he was

satisfied that the ward had not been overcrowded. As far as possible, beds would be arranged on one side of the ward and cots on the other, but even then the ward could still look 'cluttered' and orthopaedic beds looked particularly unsightly. And the Area Administrator told me that it was 'very probable having regard to the number of children in the ward at the time that in the main ward, ie the ward of sixteen beds, there could well have been additional cots or beds erected even though the total number of patients in the whole ward could still have been less than twenty-two'.

Findings

20. The Authority do not have any record of the 'mix' of cots and beds at the time and I cannot therefore be sure how crowded the main ward was. But, the Area Administrator has pointed to the probability, and the Sector Administrator to the possibility, that extra cots or beds were put up there. In these circumstances, I have no reason to discount the complainants' statement that the ward was cramped and I therefore uphold this complaint.

(ii) *The bath*

21. In his account the father said that there was 'one badly stained bath for between 10 and 20 children of various complaints – often skin complaints'.

22. In an interview with my officer the SA accepted that the ward had only one 'full-size' bath, but he said that three or four plastic baby baths were also available. He agreed that the bath was stained because the white enamel had worn away. The bath had since been replaced, as a result of the complaint.

23. In separate interviews with my officer, the three staff nurses confirmed that only one bath was available and that it was stained. But, they said, children with skin complaints were bathed last and the bath was cleaned after each use. One of them said that the availability of only one bath did sometimes present problems as it was needed for all children over two years old.

Findings

24. I find that the bath was stained; but it has since been replaced. There is only one bath and I think it probable, as one of the staff nurses said, that there are occasions when this presents problems. I have no evidence to suggest that the complainants' daughter suffered in any way because of this, but I suggest that the Authority might consider whether the bathing facilities are generally adequate. As I have found no evidence of significant hardship resulting from this complaint, I do not uphold it.

(iii) *The time children were prepared for bed*

25. In his account the father said that the children were made ready for bed at 4.00 pm.

26. The three staff nurses confirmed in their separate interviews with my officer that their practice was to start getting the children ready for bed from 4.00 pm onwards. The youngest children would be made ready first and the aim was to have all the children ready for bed between 6.30 pm and 7.30 pm. One of the staff nurses said that these times were fairly typical of children's wards, and that the complainants' daughter would not have been the first child to be made ready for bed.

Findings

27. I have no doubt that the nursing staff, with a number of children to look after, have to start the bed-time routine early if the children are to be ready for bed at the time they consider reasonable. I see no ground for criticism.

(c) *The complaint about the shortage of nursing staff*

28. In his account the father said that there was an acute shortage of staff 'One staff and one pupil nurse for twelve sick children was commonplace'.

29. The divisional nursing officer (the Div NO) told my officer that he considered staff levels at the time were adequate and so did the three staff nurses to whom I have referred previously. The Div NO said he considered that at least two qualified nurses should be on duty on the morning and afternoon shifts and at least one on the evening shift.

30. My officer examined the records of staff on duty in the ward from 7 to 15 September. He found that there were two morning shifts and one afternoon shift when there was only one staff nurse on duty, but on each of these occasions there were three untrained members of the staff in support. On every other morning and afternoon shift there were at least two trained nurses on duty, supported by at least two other members of the staff. On the evening shift there was, each day, at least one staff nurse on duty and a total of not less than three staff. At night there was always a staff nurse with either a trained or untrained nurse in support.

Findings

31. The Div NO and the staff nurses on the ward all considered the staffing to be satisfactory. And the staff records disprove the complainants' allegation that it was commonplace for only one staff nurse and one student nurse to be on duty. I do not uphold this part of their complaint.

(*d*) *The complaints about the food*

32. According to the father's account for 8 September his daughter was refusing food, but the hospital staff said that she was eating breakfast. On the day in question 'Evidence of the uneaten breakfast was before our very eyes. Food served up was a disgrace'. The father said that they had started to bring in milk as that was the only food their daughter would take, but they had been told not to do this as it was the reason why she was not eating. And in his account for 14 September her father said that he and his wife had been concerned for some time because their daughter was refusing all food, though the staff said that she was eating. A staff nurse who attempted to give the daughter breakfast admitted to the mother that she had failed to persuade her to eat anything at all, but shortly afterwards the other staff nurse on duty said that the daughter had eaten breakfast. In addition, the doctor had been informed during his afternoon ward round that she was eating – particularly breakfast.

33. In an interview with my officer the SA said that, although the general hospital menu was offered on the children's ward, in practice, children could have more or less what they wanted. As the kitchen was very close to the ward, he thought it most unlikely that the food would get cold on its way from the

kitchen to the ward. If a nurse went to the kitchen with a request for food that was not on the menu, it would be taken straight to the ward. Fresh milk was always freely available. The Div NO told my officer that the proximity of the paediatric ward to the kitchen made it very easy to cater for individual needs, and similar comments were made by the three staff nurses, who did not share the father's view that the food was poor.

34. Following their investigation the Authority said that the complainants had been advised not to bring in milk as there was sufficient in the hospital. Only one of the staff nurses interviewed by my officer could remember anything about this. She recalled having been told by a member of the nursing staff that the complainants had been asked not to bring in milk.

35. The staff nurse who was on duty when the complainants visited the hospital on 14 September told my officer that breakfast was served in the play-room at about 8 o'clock, and that the complainants normally came into the ward at about 9 o'clock. She always made a point of telling them whether their daughter had eaten breakfast. On 14 September she had refused breakfast (an entry in the nursing notes confirms this) and the staff nurse had told the parents of this. The father had been upset about his daughter's treatment and told her that another staff nurse had informed him that his daughter had eaten breakfast. The staff nurse told my officer that, as she was the only staff nurse on duty that morning (and I have confirmed that this was so), she had invited the father to identify the other staff nurse. He had then apologised.

36. In his written comments to the Authority during their investigation the paediatric senior house officer (the SHO) said that when he had seen the complainants' daughter on his ward round her father had expressed dissatisfaction with her treatment and had said that she was not eating. The nurse accompanying him said that she usually ate a good breakfast. The SHO said that he had no reason to disbelieve her.

37. The nurse in question said, in her written comments to the Authority, that she had not told the doctor that the complainant's daughter had eaten that day; what she had said was 'she has been eating'. She went on to say that she always read the morning report beforehand, to ensure that she was giving the doctor the correct information, and she would have the report with her when she accompanied the doctor on the ward round. I have confirmed that the nursing record states that the daughter did not eat breakfast that day.

Findings

38. On the evidence I have obtained I cannot uphold any of these complaints. It is impossible for me to establish the quality of the food in 1978, particularly when the only information the father provided was that it was 'a disgrace'. I regard the complaint about the milk as trivial and I dismiss it. As to the complaint about the conflicting information, the nursing notes record that the daughter refused food on the morning concerned. I have no reason to suppose that the entry is incorrect, and I think it most unlikely that the nurse would have misinformed the doctor.

(*e*) *The complaint that the complainants' daughter contracted a cough and a cold*

39. The father said that when he visited his daughter on 8 September she had

been bathed and her hair had been left soaking wet 'supposedly part of her treatment'. Windows and the fire exit door were continually left open, and he had questioned leaving her hair wet in such cold and draughty conditions. When he visited her on 10 September he said that she had 'a bad cough and cold' which in his opinion was a result of 'soaking her hair and the draughts'.

40. As a result of their investigation the Authority said that the daughter's hair was being treated with oils and creams and these made it look wet; but that after the complainants had twice been reassured on this point by the medical and nursing staff they were satisfied. As to the draughts, the Authority said that it had been very warm when the daughter was a patient. The ward tended to become very hot and stuffy and the only way to overcome this was to open some of the doors and windows. In view of the position occupied by her cot they thought it unlikely that there would have been any 'unpleasant cold draughts'.

41. The medical and nursing notes record that the daughter's skin condition was being treated with an emulsifying cream; and the consultant and members of the nursing staff told my officer that this did, in fact, make the hair look wet. One of the staff nurses said that if they had not the time to dry a child's hair they would not wash it in the first place. And, in a written statement, she said that the complainants had themselves carried out the treatment under supervision and had appeared satisfied. The nursing notes for 10 September record – 'Parents advised re child's hair treatment'.

Findings

42. I do not uphold this complaint. I think it is clear that it was the application of the cream that was making the hair look wet. And I am satisfied that this was explained, and indeed demonstrated, to the complainants. The clinical notes for 7 September record that on admission their daughter had a 'cough – barking type' and on 14 September '(cough but chest clear)'. I do not believe that she contracted a cold while in hospital.

(f) The complaint about the playschool

43. The father said in his account that, because his wife had not been well enough to visit their daughter on 13 September, she had telephoned the hospital and had been told that she was in the playschool and was not fretting. But a relative who visited her in the playschool at 11 am that day was appalled to find her ignored, obviously poorly, with a high temperature, and with no pants, socks or shoes on. The father said that he arrived at the hospital at 12.15 pm and advised his wife of 'the diabolical situation'. Although the wife was ill in bed, she had got up and gone straight to the hospital.

44. When interviewed by my officer the play therapist said that at about 10.45 am on 13 September she had told the nurses that she was going to have her coffee break. As far as she could recall the complainants' daughter was fully clothed when she left her but, as she was at her coffee break when the relatives visited her, she could not say in what state she had found her.

45. As a result of their investigation the Authority said that the complainants' daughter appeared to be enjoying her stay in the playschool. On one occasion she had been unable to get to the lavatory in time and the nurse in charge had

gone to get 'clean changes' for her. A relative had then arrived. When the nurse returned the daughter was wrapped in a blanket and was being nursed by the relative. The staff nurse on duty was informed of this and she said that the daughter needed to be kept as cool as possible (the medical notes record that she had a temperature). The relative immediately co-operated and made no complaints.

Findings

46. The Authority do not dispute that the complainants' daughter was without pants when a relative visited her in the playschool on the day in question, but I have been unable to establish how long she had been in that state. Although she may have been alone when the relative saw her when, I believe, a nurse was getting a change of clothes, I doubt whether she remained unattended for more than a short time.

(g) *The complaint that the complainants' daughter was dragged by the sister*

47. In his account the father said that when the consultant saw his daughter on 25 September he had taken the unusual step of having her weighed, and that 'a sister (nursing) dragged [her] trying to make her walk back after the weighing. (She failed)'. He added that his wife had been appalled.

48. In an interview with my officer the sister said that the complainants' daughter was reluctant to go with her to be weighed. The daughter had nonetheless walked to the bathroom with her and, although she struggled a bit, she (the Sister) had been able to weigh her. She and a relief nurse (who cannot now be traced) took her back, still struggling, to the admissions room where the mother had remained. The sister said that when they entered the admissions room she thought that the daughter was going to fall and she had therefore caught hold of her, lifted her up, and carried her to her mother. She had certainly not 'dragged' her. She had worked at the hospital for some twenty years and was used to dealing with children.

49. My officer visited the admissions room and found that, even if the door of the room had been open, it would have been impossible for the mother to have seen the sister and the daughter approaching it along the corridor from the bathroom.

Findings

50. I think it very unlikely indeed that the sister 'dragged' the complainants' daughter. I am satisfied that the mother would not have seen the sister and the daughter returning to the admissions room after the child had been weighed. I cannot be certain what happened at the door of the admissions room but I have no reason to doubt the sister's explanation that her concern was to prevent the daughter from falling. I do not uphold this complaint.

(h) *The complaint about the discrepancy in the daughter's weight*

51. The father said that the weight as recorded at the hospital on 25 September was 12.1 kilos but when she was weighed at the second hospital a few hours later it was 10.5 kilos.

52. The medical notes at the hospital record the daughter's weight as 12 kilos on 7 September, 11.3 kilos on 12 September and 12.1 kilos on 25 September. The records at the second hospital record her weight as 10.4 kilos on 25 September.

53. The Authority told me that they thought a possible reason for the discrepancy on 25 September was that at the first weighing, the daughter was clothed and, at the second, unclothed.

Findings

54. I do not believe that the discrepancy of 1.7 kilos on 25 September could have been accounted for simply by the weight of the clothes and I am unable to explain it. But it seems to me likely that at the hospital she was weighed clothed when she arrived there on 7 September, unclothed when she was an in-patient on 12 September, and clothed when she was an out-patient on 25 September. And the discrepancy of some 0.7 kilos was almost certainly accounted for by this. I can say no more than that I find no obvious inconsistency in the records of the hospital.

(i) *The complaint that a member of the nursing staff implied that the father had been a nuisance*

55. In his account the father said that the house officer whom he had approached about his daughter's treatment that day had refused to comment. The staff nurse on duty had then asked the father whether he wished to enter a complaint in the complaints book and had intimated that he had been a nuisance for some time. He said that he and his wife were 'disgusted at this heartless, thoughtless, even cruel state of affairs'.

56. The staff nurse concerned said, in written comments to the Authority, that the father came to the office complaining that he was not satisfied with his daughter's treatment. She had asked a doctor on the ward to talk to him but he was not satisfied with the explanation he was given. She had therefore offered him the complaints book and asked him if he would like to see a nursing officer, but he had declined both these offers. Later that afternoon he had apologised to her for his 'outburst', and said that he had been upset by what the relative had told him about the incident in the playroom that morning (see paragraph 43). The staff nurse said that she thought the complainant's were satisfied when they left the hospital that afternoon. In an interview with my officer she confirmed what she had said. And I have seen an entry in the nursing notes for 13 September which reads 'Father full of complaints this afternoon complaints book offered – same refused'.

Findings

57. The father was obviously dissatisfied with the way his daughter had been treated, and he said so. In offering him the opportunity to register a formal complaint, the staff nurse was following normal practice and I find nothing to support his complaint.

(j) *The complaint about the Authority's response*

58. Following a meeting with the Area Medical Officer (the AMO) on

26 October 1978, the father submitted a long and detailed written complaint to the Authority which was acknowledged on 1 November. In his statement to the Authority he complained not only about the administration aspects of his daughter's case but also about the medical management of her case (which is outside my jurisdiction). And, in the early stages of the Authority's investigation, the solicitors wrote to them drawing attention to 'the allegation of gross negligence and incompetence which my clients are making against [the consultant] and [the] hospital'.

59. Because of these serious allegations the Authority felt the need to consult their legal advisers as well as the many people directly involved in the complaint and the Authority's senior officers.

Findings

60. I have seen the Authority's correspondence file which, apart from statements by those concerned contains some 70 documents. I have found no evidence of undue delay in pursuing the many detailed allegations contained in this complaint and I find their investigation of it to have been thorough and their reply to it comprehensive. I do not uphold this aspect of the complaint.

Conclusion

61. I give my findings in paragraphs 16, 20, 24, 27, 31, 38, 42, 46, 50, 54, 57 and 60 of this report. I have the deepest sympathy for the complainants in the tragic loss of their daughter at such an early age. But, apart from my finding in paragraph 20, I find no substance in any of their complaints.

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